

6-1-1987

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Recommended Citation

Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 Loy. L.A. L. Rev. 1329 (1987).

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COMPELLING TREATMENT IN THE COMMUNITY: DISTORTED DOCTRINES AND VIOLATED VALUES*

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[T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right.¹

But the existence of such laws has passed away with the narrow views which produced them; and the improved knowledge of the present day, on the subject of mental alienation, would not tolerate a course of treatment which was once deemed not only judicious, but a measure of absolute necessity. It has been impressively and eloquently said, that every man is interested in this subject; for no man can reckon on the continuance of his perfect reason. Disease may weaken, accident may disturb, anxiety may impair it; and if every departure from sound mind may subject the person so affected to an indiscriminate treatment, including deprivation of property and liberty, no man can be sure that he may not, with a full consciousness

* This Article is dedicated to Mary Crapo who was committed to providing people with choices and whose determined spirit would be offended by any form of coerced treatment.

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The authors wish to express their appreciation for the guidance and critical analysis provided by Ingo Keilitz, director of the Institute on Mental Disability and the Law, National Center for State Courts. The Institute's success in clarifying and publicizing the issues of civil and outpatient commitment has generated invaluable resource material which facilitated the preparation of this Article.

1. J. MILL, *On Liberty*, in 43 GREAT BOOKS OF THE WESTERN WORLD 269, 271 (R. Hutchins ed. 1952).

of his suffering and wrongs, be one day treated as if all sense and feeling in him were destroyed and lost; torn from his family, from his home, from his innocent but eccentric pursuits²

TABLE OF CONTENTS

I.	Introduction	1330
II.	The State's Authority to Confine or Commit	1336
	A. Development of the State's <i>Parens Patriae</i> Authority ..	1336
	B. Outpatient Commitment	1346
III.	The Doctrine of the Least Restrictive Alternative	1348
IV.	The Current Status of State Law	1360
	A. State Statutory Provisions for Involuntary Outpatient Commitment	1362
	1. Statutory authorization and substantive standards .	1363
	2. Procedural safeguards and implementation mechanisms.....	1369
	B. Conditional Release	1372
	C. Judicial Interpretations of the Outpatient Statutes	1374
V.	The Implementation Maze.....	1377
	A. The Availability of Community Services	1378
	B. Compelling Compliance with a Treatment Regimen ...	1380
	C. The Few People Left to Commit	1385
	D. The Resistance of Community Mental Health Agencies	1386
	E. The Expanded Judicial Role	1389
	F. Community Acceptance of Committed Persons	1391
	G. The Risk of Liability	1393
	H. Expanded Entitlement to Community Services	1396
VI.	The Massachusetts Model	1397
VII.	Conclusion.....	1403
	Appendix	1405

I. INTRODUCTION

We have inherited a history of confining people with mental disabilities and depriving them of the ordinary rights of citizenship, allegedly for their own good. The establishment of places to care for those labeled

2. *Colby v. Jackson*, 12 N.H. 526, 533 (1842) (quoting CONOLLY'S INDICATIONS OF INSANITY 8).

"disordered" has traditionally followed periods of increased awareness of their suffering. These phases of "reforms" were quite literally institutionalized through systems which usually prioritized care over freedom, cures over preferences and compulsion over consent. Civil commitment was and continues to be the legal rubric that sanctions this offer of generosity which cannot be refused.

This history can be traced to at least the fourth century B.C., when the first sanatorium was built in Greece in response to a burgeoning interest in curing afflictions of the mind.³ For the next two thousand years, society's concern for people branded as "lunatics"⁴ was primarily limited to those with means. The poor were left alone. When the disturbance of their differences or the threat of their presence became too great, the poor were herded to almshouses, jails or simply the edge of town.⁵ In the nineteenth century, another wave of concern produced new buildings solely for housing people with mental illness.⁶ These segregated environments offered so much promise of improvement that legislatures enacted statutes to ensure that the offer was accepted. Subsequently, the authority to compel care was expanded considerably, so that the promise of unproven treatments could be provided to all in apparent need.⁷

3. S. BRAKEL, J. PARRY & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 9 (3d ed. 1985); see also BIGGS, *THE GUILTY MIND: PSYCHIATRY AND THE LAW OF HOMICIDE* 3-34 (1955).

4. The word was officially first used in the statute *De Praerogativa Regis* which was enacted in England between 1255 and 1290. 1 W. HOLDSWORTH, *A HISTORY OF ENGLISH LAW* 473 (7th ed. 1956); 2 F. POLLOCK & F. MAITLAND, *THE HISTORY OF ENGLISH LAW* *464 (1959). This law was intended to distinguish a lunatic as a person "who hath understanding, but . . . hath lost the use of his reason" from one who "hath no understanding from his nativity." S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 10. Today the labels "mentally ill" and "mentally retarded" serve the same misguided purpose.

5. See generally A. DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* (1949). The situation apparently was similar in Europe. See S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 12-13; MADHOUSES, MAD-DOCTORS, AND MADMEN 166-92 (A. Scull ed. 1981).

6. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 13-16; A. DEUTSCH, *supra* note 5, at 114-15, 186-87. Dorothea Dix was the champion of this capital construction campaign in America. Although the development of places to keep people and methods to improve them has been uneven during the millenium, the pace has accelerated dramatically over the past two centuries. Similarly, the locations where those labeled mentally infirm are confined increased exponentially, as measured by either the number, capacity, or design of these environments. Within the walls of these places, technological innovations and institutional order combined to create an impressive list of deprivations which were routinely imposed on individual residents; they ranged from mind-altering surgeries to a modified version of an infant's high chair that had bed sheets tie the person in. This latter device is still common on most wards of today's mental hospitals where elderly persons are confined.

7. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 15-16. By 1960, virtually every state in the nation had passed laws authorizing the involuntary confinement and treatment of people with mental disabilities who were determined to "need treatment." See *Developments*

As these facilities became too full and embarrassingly inadequate by the mid-twentieth century,⁸ another expression of concern arose which blended psychiatry's promise of cure through drugs, the law's guarantee of dignity through process and a mental health policy of care through community services.⁹ When critics later labeled this latest expression an uncompassionate failure,¹⁰ a new wave of proposals to confine people emerged. The most far reaching of these is outpatient commitment, sometimes termed involuntary community treatment.

Outpatient commitment is not a unified concept with a commonly accepted definition or consequence. For this Article's purposes, it will be defined as a judicial order, entered pursuant to a state's civil commitment

in the Law: Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1194-97 nn.11-14 (1974) [hereinafter *Developments*].

8. The outcry was reflected in media exposes such as the noted one of the Willowbrook Institution filmed by Geraldo Rivera. Willowbrook was a mammoth and embarrassing retardation facility in Staten Island, New York. See D. ROTHMAN & S. ROTHMAN, *THE WILLOWBROOK WARS* 44-46 (1984). It was also documented in judicial findings. *Wyatt v. Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971), *aff'd in part and rev'd in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305, 1310-12 (5th Cir. 1974). Horrors of institutional life are not a recent phenomenon; commentators for centuries have described the abuses routinely experienced by inmates of large facilities. See generally A. DEUTSCH, *THE SHAME OF THE STATES* (1948). Nineteenth century reformers, in their eagerness to save the mentally ill from the pain of community exposure and social integration, merely ignored this reality.

9. The medical profession heralded the discovery of antipsychotic medications and policymakers relied upon them as the clinical justification for depopulating state hospitals. With the advent of these psychopharmacological drugs (e.g., bromides, barbituates, chlorpromazine, meprobamate, reserpine and chloroxipide), mental illness could apparently be treated outside of a hospital setting. See J. TALBOTT, *THE DEATH OF THE ASYLUM* 26 (1978). Simultaneously, the legal profession awakened to the constitutional implications of involuntary commitment, which entailed a "massive curtailment of liberty." *Humphrey v. Cady*, 405 U.S. 504, 509 (1972). Successful litigation soon resulted in heightened standards of commitment and expanded procedural safeguards. See *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on procedural grounds*, 414 U.S. 473 (1974), *reinstated*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *reaff'd*, 413 F. Supp. 1318 (E.D. Wis. 1976).

Public officials both anticipated and followed these developments. President Kennedy provided courageous leadership in urging passage of a federal initiative to encourage the creation of community mental health services. See *Mental Retardation Facilities and Community Mental Health Centers Construction Act*, Pub. L. No. 88-164, 77 Stat. 282 (1963), *repealed by* Pub. L. No. 97-35, § 902(e)(2)(B), 95 Stat. 560 (1981). Local legislators often needed to be pressed by the courts. *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975); *Brewster v. Dukakis*, No. 76-4423-F (E.D. Mass. Dec. 6, 1978) (final consent decree), *reprinted in* 3 *MENTAL DISABILITY L. REP.* 45 (1979), *enforced*, 544 F. Supp. 1069 (D. Mass. 1982), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986).

This history is well summarized in Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 388-400 (1983-84).

10. See Bachrach, *An Overview of Deinstitutionalization*, in *DEINSTITUTIONALIZATION* 5, 10-13 (L. Bachrach ed. 1983); see also H. WILSON, *DEINSTITUTIONALIZED RESIDENTIAL CARE FOR THE MENTALLY DISORDERED* 110-11 (1982); Myers, *supra* note 9, at 403.

scheme, which compels a person to participate in mental health programs and to comply with a court-approved treatment regimen outside of the walls of a mental institution. This understanding of the term has been endorsed by leading judicial organizations¹¹ and commentators.¹² This may be the end of the consensus on the subject.

Proponents perceive outpatient commitment as the panacea for two decades of abuse in deinstitutionalization policies and libertarian modifications to civil commitment standards. They present it as a sensible application of the doctrine of the least restrictive alternative—a constitutional principle used to analyze the legitimacy of governmental restrictions on individual liberties which only recently has been applied to civil commitment.¹³ In the name of outpatient commitment, some urge a modification of involuntary commitment standards to encompass persons not presently dangerous or not dangerous at all, but who would ultimately benefit from forced treatment.¹⁴ Others suggest a radical expansion of the places where people are confined—from traditional institutions to community mental health residences or crisis shelters.¹⁵ The reform promises that some people labeled mentally ill may not need to be physically confined at all, provided they can be compelled to comply with a treatment plan and conform their behavior to a clinically prescribed norm. Thus, outpatient commitment's apparent attractiveness lies in the expanded authority to require people with mental disorders to accept psychiatric interventions without necessarily being institutionalized.

Not surprisingly, critics of outpatient commitment disagree that it will be any more of a successful cure than were massive institutions, medication clinics or cold packs.¹⁶ They point out that even the most avid proponents cannot agree on what outpatient commitment means; whether major statutory revisions in state law are necessary or desirable

11. See, e.g., INSTITUTE ON MENTAL DISABILITY AND THE LAW & THE NATIONAL CENTER FOR STATE COURTS, A MODEL FOR THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN INVOLUNTARY CIVIL COMMITMENT 363 (1984) [hereinafter LRA REPORT]; NATIONAL CENTER FOR STATE COURTS, GUIDELINES FOR INVOLUNTARY CIVIL COMMITMENT, 10 MENTAL & PHYSICAL DISABILITY L. REP. 409, 497 (1986) [hereinafter COMMITMENT GUIDELINES].

12. Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 CLEV. MARSHALL L. REV. 93 (1967); Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54 (1982); Myers, *supra* note 9, at 418-19.

13. For a discussion of the principle and its application to the involuntary confinement of mentally disabled persons, see *infra* notes 83-129 and accompanying text.

14. Myers, *supra* note 9, at 418-20, 427.

15. Bleicher, *supra* note 12; see also COMMITMENT GUIDELINES, *supra* note 11, at 512.

16. Morse, *supra* note 12, at 96.

in order to accomplish its goals; whether compulsory community care is feasible, considering the myriad of obstacles to its implementation; or if it will achieve the desired outcomes, which are themselves unclear and often contradictory.

For outpatient commitment to be clinically appropriate and politically acceptable, it will almost certainly require expanding the standards for compulsory treatment beyond those which now determine involuntary institutionalization. This expansion is not only predictable, given the public pressure for relaxed commitment criteria,¹⁷ but also inevitable, since no one would easily tolerate the compelled attendance of dangerous persons in local neighborhood mental health programs.¹⁸ In fact, the primary purpose of the entire outpatient commitment proposal is to coercively intervene with psychiatric treatment *before* a person becomes dangerous, unable to care for himself or otherwise subject to current state laws for involuntary hospitalization.¹⁹ This is precisely what has happened in states which have adopted a comprehensive outpatient scheme.²⁰

17. The psychiatric profession has long been critical of current commitment requirements and has advocated a lowering of the threshold for involuntary treatment. See Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976); Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983). Legal scholars rest their case for outpatient commitment as much on the benefits of these broader criteria as on the attractiveness of treatment in noninstitutional programs. See Bleicher, *supra* note 12, at 103; Myers, *supra* note 9, at 427-28. But all commentators and public policy observers recognize the reality that the current trend to authorize coerced community care almost invariably incorporates a modified commitment standard. See Bursten, *Posthospital Mandatory Outpatient Treatment*, 143 AM. J. PSYCHIATRY 1255 (1986); Miller & Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment?*, 35 HOSP. & COMMUNITY PSYCHIATRY 147, 149 (1984); I. Keilitz, *Involuntary Outpatient Civil Commitment* 33, 42 (1986) (unpublished manuscript available from the Institute on Mental Disability and the Law, National Center for State Courts); J. Owens, *Involuntary Outpatient Commitment* 34 (Nov. 1985) (unpublished paper prepared for the National Institute of Mental Health, Division of Educational Services Systems Liaison).

18. See *infra* text accompanying notes 275-78.

19. See Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L. REV. 83, 100-02 (1986); Miller & Fiddleman, *supra* note 17; Editorial, *Outpatient Commitment: The Problems and the Promise*, 143 AM. J. PSYCHIATRY 1270 (1986) [hereinafter Editorial]. Under this professed humanitarian concern to force treatment as a response to psychological deterioration, outpatient commitment has rapidly become the vehicle for rather radical modifications to substantive civil commitment standards.

20. Six states—Arkansas, Georgia, Hawaii, Kansas, North Carolina and Tennessee—have recently enacted statutes which authorize involuntary community care. Each includes a substantial modification of institutional commitment standards. ARK. STAT. ANN. §§ 59-1415(c), 1409 (Supp. 1985); GA. CODE ANN. § 37-3-81 (Harrison Supp. 1985); HAW. REV. STAT. § 334-127(b) (1985); KAN. STAT. ANN. § 59-2918(a) (Supp. 1986); N.C. GEN. STAT. §§ 122C-263(d)(1) (Supp. 1985); TENN. CODE ANN. § 33-6-104 (Supp. 1986). See Keilitz & Hall, *State*

To pursue this questionable reform in the name of the *parens patriae* and least restrictive alternative principles is to distort those doctrines and to violate their underlying values. Conversely, to respect these legal restraints on governmental power and maintain current commitment criteria would avoid the conceptual difficulties of involuntary community treatment. As a practical matter, however, it might leave few people actually eligible, in the eyes of local judges and neighbors, for release from state institutions and forced participation in community mental health services.²¹ If outpatient commitment does not widen the net—as it most surely will—there may be no one to catch in the beneficent paternalism of coerced community care.

We may be on the verge of making another monumental mistake in our zeal to care for, protect and fix those whom we label mentally ill. Outpatient commitment is neither conceptually correct nor practicably feasible. This Article takes the position that involuntary community treatment is a flawed idea which will benefit few and may harm many. Part II examines the legal justification for civilly restraining people labelled mentally ill to further their own welfare, which forms the theoretical foundation for outpatient commitment. Part III analyzes the doctrine of the least restrictive alternative to determine whether coerced community care is a proper application of this constitutional precept. Part IV surveys current state law on outpatient commitment, both statutory requirements and judicial decisions, based upon a comprehensive study by the National Center on State Courts. Part V identifies several practical obstacles to the implementation of involuntary community treatment. Of particular significance is whether outpatient commitment is feasible absent a system of community mental health services (the reality in most jurisdictions) or whether it is necessary in the presence of such a system, as exemplified in Massachusetts. The Massachusetts model is described in Part VI. Finally, some conclusions are presented concerning the probable consequences of expanding the civil commitment network into our neighborhoods and communities.

Statutes Governing Involuntary Outpatient Civil Commitment, 9 MENTAL & PHYSICAL DISABILITY L. REP. 378 (1985).

A detailed analysis of each state's outpatient commitment statute is set forth *infra* in the Appendix. The charts were prepared by the Institute on Mental Disability and the Law of the National Center on State Courts. They represent the most comprehensive comparison to date of the provisions in all fifty states and the District of Columbia that sanction the forcible treatment of people in noninstitutional settings.

21. See *infra* text accompanying notes 252-56.

II. THE STATE'S AUTHORITY TO CONFINE OR COMMIT

A. *Development of the State's Parens Patriae Authority*

Cases and commentators regularly point to two justifications for civil commitment—the state's police power and its *parens patriae* authority.²² The former is primarily limited to protecting the safety and welfare of the community and preventing harm to third persons.²³ For several centuries, it provided the only justification for confining people labeled mentally ill.²⁴ From feudal times through the development of the common law in colonial America, the fundamental right of physical freedom could only be denied to those considered mentally ill if they posed a substantial danger to others. Neither the king nor subsequent state governments could involuntarily confine handicapped persons except to protect the community from harm. Thus, while the needs and limitations of dis-

22. *Lynch v. Baxley*, 386 F. Supp. 378, 390 (M.D. Ala. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972), *vacated and remanded on procedural grounds*, 414 U.S. 473 (1974), *reinstated*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *reaff'd*, 413 F. Supp. 1318 (E.D. Wis. 1976). See *Dix, Major Current Issues Concerning Civil Commitment Criteria*, 45 LAW & CONTEMP. PROBS. 137 (Summer 1982); La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFFALO L. REV. 499 (1981); Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968) [hereinafter Livermore]; Morse, *supra* note 12; Myers, *supra* note 9; *Developments*, *supra* note 7.

23. There is some disagreement with respect to the relevance of this authority to prevent injury to the mentally ill individual. Some writers argue that commitment to prevent danger to self, attempted through intentional, self-destructive acts or inadvertence, is an expression of society's responsibility to prevent harm to its members and therefore an exercise of the police power. See Hermann, *supra* note 19, at 94-95; La Fond, *supra* note 22, at 501 n.9. This view has considerable support in history, see S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, and has been accepted implicitly by the United States Supreme Court. See *Addington v. Texas*, 441 U.S. 418, 426 (1979). Others reason that any action to protect an incompetent individual is more properly taken under the state's *parens patriae* authority. *Developments*, *supra* note 7, at 1223-28; see also *Lessard*, 349 F. Supp. at 1085. But even this second approach makes a sharp distinction between *parens patriae* interventions to ensure the individual's physical safety—a well established societal obligation that was transferred from its original police power foundation—and actions to improve the person's health or welfare—a recent innovation that is grounded on a questionable view of governmental responsibility. State commitment statutes almost uniformly include a standard authorizing confinement for the former, usually under the terms "danger to self" and "gravely disabled," but only a few jurisdictions allow involuntary institutionalization for the latter. See S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 114-21 table 2.6.

24. In England, the Crown had the absolute privilege to restrain violent persons who also happened to "fail of their wit." S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 10, 12-14. This authority was incorporated in the common law. See A. DEUTSCH, *supra* note 5, at 419-20. Statutes translating this common-law power to colonial authorities appeared in Massachusetts as early as 1676. 5 RECORDS OF THE GOVERNOR AND COMPANY OF THE MASSACHUSETTS BAY IN NEW ENGLAND 77 (N. Shurtleff ed. 1854). By the late eighteenth century, many of the original states had enacted similar provisions. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 14.

abled persons may have been widely ignored by public authorities,²⁵ their liberty interests were not.²⁶ This police power rationale still forms the principal basis for most state commitment statutes.²⁷ But because it is directed towards detaining dangerous persons in secure settings, it has little relevance to outpatient commitment.

The *parens patriae* authority extends the mantle of government protection, and its authority to commit, to incompetent persons who pose a danger to themselves.²⁸ Compelling mental health treatment in community settings does not represent a legitimate exercise of this power since it is commonly undertaken not to protect a dangerous, incompetent person from physical harm, but instead to ensure that a competent individual receives coerced treatment outside of an institution.²⁹ The extraordinary extension of the *parens patriae* power implied in most outpatient commitment proposals is neither consistent with its historical purpose and common law development nor supported by any compelling state interest sufficient to override the fundamental rights at stake. Legal proponents have had to distort its foundation and misinterpret two hundred years of sparse case references to claim a theoretical justification for compulsory

25. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 10-12; A. DEUTSCH, *supra* note 5, at 123-25.

26. 1 W. BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND *304 (1885). Statutes including standards for dangerousness were promulgated as early as the sixteenth century. See *supra* note 24. Even up to the mid-nineteenth century, some courts still resisted the notion that restrictions on a person's liberty could be imposed solely because of the alleged insanity:

[S]uch an authority is possessed by no person, unless under the sanctions, and after compliance with the forms, of law. No relationship, however near; no ties of friendship, however close, between the lunatic and his keeper, would render the existence of such a rule consistent with the safety of the community. Every cage would be a licensed private mad-house; and, added to the nameless and unimaginable horrors which have been brought to light in such establishments in England, even under the treatment of medical men, and regulated by acts of parliament, would be the further evil, that each individual keeper would be irresponsible. Any citizen could confine his neighbor, provided only he were insane; and if the confinement were to continue as long as the insanity, both would probably end only with the life of the patient; imprisonment in a cage not being supposed to be the most efficacious mode of restoring an insane man to his reason.

Colby v. Jackson, 12 N.H. 526, 532 (1842).

27. See S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 114-21 table 2.6, col. 4; Hermann, *supra* note 19, at 94 n.60 (summarizing state statutes). For an earlier list, see *Developments*, *supra* note 7, at 1203 n.11.

28. The state's responsibility to protect the safety and financial interests of its incapable citizens is a vague though long-standing aim of government. *Developments*, *supra* note 7, at 1207-09. Its origins in English law reflected a "concern for the property of the disabled, with little attention given to his person." S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 10.

29. COMMITMENT GUIDELINES, *supra* note 11, at 497-99 guideline G2 and commentary; Miller & Fiddleman, *Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C.L. Rev. 985, 1019-20 (1982) [hereinafter *Commitment in North Carolina*]; Myers, *supra* note 9, at 418-19.

community care.³⁰

The development of this *parens patriae* authority is hardly extensive or well-conceived. It can be traced to the power of the English Crown to safeguard the property interests of individuals deemed to be incompetent or insane.³¹ As the protector of his wards' estates, the king was obligated to exercise his authority to ensure only that no material harm was done. This responsibility differed depending on whether the handicapped person was labeled a "lunatic" or an "idiot."³² The Crown could temporarily manage the property of "lunatics" as long as they remained disabled. All funds had to be applied to their daily expenses. For "idiots," however, the Crown could retain the profits from their property, after devoting an appropriate amount to "necessaries."³³ Implicit in this broader power was the permanent responsibility for the welfare of its retarded wards. Thus the *parens patriae* doctrine established the king as no more than a temporary trustee over the property of people labeled mentally ill. Safeguarding their health—to say nothing of confining their persons—was unheard of.³⁴

This majestic concern with property was transported to the Amer-

30. See *O'Connor v. Donaldson*, 422 U.S. 563, 582-83 (1975) (Burger, C. J., concurring); Hermann, *supra* note 19, at 94. To argue that the dramatic expansion of the *parens patriae* authority which occurred in this country from the mid-eighteenth to the mid-nineteenth century was a natural evolution true to "the beneficent purposes underlying the doctrine" is simply incorrect. Myers, *supra* note 9, at 387-88. The better view of history and constitutional authority can be found in Morse, *supra* note 12.

It ultimately required a virtual avalanche of federal court decisions to stem this expansionist tide and return the *parens patriae* commitment to a dangerousness standard. *Colyar v. Third Judicial Dist. Court*, 469 F. Supp. 424, 430-31 (D. Utah 1979); *Stamus v. Leonhardt*, 414 F. Supp. 439, 450-51 (S.D. Iowa 1976); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1121-24 (D. Haw. 1976), *modified sub nom. Suzuki v. Yuen*, 438 F. Supp. 1106, 1109-10 (D. Haw. 1977), *aff'd in part and rev'd in part*, 617 F.2d 173, 176 (9th Cir. 1980); *Doremus v. Farrell*, 407 F. Supp. 509, 514-15 (D. Neb. 1975); *Kendall v. True*, 391 F. Supp. 413, 417-19 (W.D. Ky. 1975); *Lynch v. Baxley*, 386 F. Supp. 378, 390 (M.D. Ala. 1974); *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085, 1096 (E.D. Mich. 1974); *Lessard*, 349 F. Supp. at 1093-94.

31. Originally, the lord of the fief was both master of his serfs and trustee of their assets if they became of "unsound mind." 1 W. HOLDSWORTH, *supra* note 4, at 473. It was the lords' abuse of this power and disregard for their serfs' welfare that forced the Crown to assume this responsibility. See 1 W. BLACKSTONE, *supra* note 26, at *304-05. Thus, from its inception, the *parens patriae* doctrine was a limited grant of governmental authority, necessitated by the excessive control and irresponsible actions of the guardians of disabled persons.

32. The current fascination with categorizing people with handicaps had an earlier origin. See *supra* note 4 for a definition of these terms with their modern counterparts.

33. The king's responsibility was codified in the statute *De Praerogativa Regis*. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 10. For a thorough review of the English history of this doctrine, see 2 F. POLLOCK & F. MAITLAND, *supra* note 4, at *481. A well-referenced summary can be found in Myers, *supra* note 9, at 380-84.

34. Judge Neeley made this point forcefully and convincingly in a scholarly review of the *parens patriae* doctrine in *State ex rel. Hawks v. Lazaro*, 157 W. Va. 417, 427-30, 202 S.E.2d

ican colonies via the common law. Subsequently, the authority was vested in legislatures which enacted guardianship mechanisms to oversee the interest of minors, incompetents and persons otherwise incapacitated.³⁵ Even the more expansive expressions of the *parens patriae* authority were originally confined to financial matters. For instance, in *Rebecca Owings' Case*,³⁶ the Maryland Court of Chancery obviously strained to construct a rationale for protecting the property interests of a woman labeled mentally ill who was due, but was being denied, a portion of her inheritance.³⁷ The court simultaneously acknowledged that this authority could never sanction the confinement or control of the person. Related decisions focused exclusively on money management.³⁸ Rather than representing an extension of the *parens patriae* power, as is sometimes contended,³⁹ these early cases merely reaffirmed the traditional

109, 117-20 (1974). There is little support, in case law or commentary, for implying great humanitarian purposes to the original concept.

As *Praerogativa Regis* is basically a tax statute clarifying feudal incidents, it is as difficult to find the fountainhead of a modern humanitarian doctrine in 17 Edward II, Chapters 9 and 10 as it is to find some great state beneficence underlying the modern Internal Revenue Code. Chapter 10 was at best a limitation on the avaricious designs of the sovereign in the case of lunatics, which has been given unbridled license by Chapter 9 of the same statute with regard to the lands of born idiots or natural fools.

....
The ineluctable conclusion follows that the early development of *parens patriae* was in no way evidence of the sovereign's solicitude for the welfare of unfortunate subjects, but rather was merely the natural result of the king's need for revenue combined with medieval restraints upon the alienation of land which left valuable life estates in the hands of born incompetents under a system of feudal as opposed to modern allodial tenure, for in those days it can be said with ironic force that the law was no respecter of persons.

Id. at 428-29, 202 S.E.2d at 118-19 (emphasis in original).

No support can be mustered nor reference cited which allowed the state to legitimately compel a disabled person to submit to its compulsory protection by sacrificing his liberty. On the contrary, the *parens patriae* power was necessary to curb such abuse in local lords and was intended to be a narrowly-tailored device to safeguard wealth. See 2 F. POLLOCK & F. MAITLAND, *supra* note 4, at *481; *Developments, supra* note 7, at 1212 n.66. Cf. Myers, *supra* note 9, at 382 n.73, 384.

35. *Developments, supra* note 7, at 1208-09; see also A. DEUTSCH, *supra* note 5, at 422-23. These broad protective measures still did not incorporate the authority to confine disabled persons for their own good. Involuntary commitment was reserved for the "violent and dangerously insane." S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 22.

36. 1 Bland's Ch. 290 (Md. Ch. 1827).

37. The court stated: "The case is of a delicate and anomalous nature; yet it is one in which, it is quite evident, that relief, by some means or other, ought to be granted. There are, however, difficulties in the way, which must be overcome or removed." *Id.* at 292.

38. *In re Mason*, 1 Barb. 436 (N.Y. App. Div. 1847); *In re Barker*, 2 Johns. Ch. 232 (N.Y. Ch. 1816).

39. See Myers, *supra* note 9, at 385-86; see also La Fond, *supra* note 22, at 504-06. The "sweeping" approval of the *parens patriae* authority pointed to by some in the language of a few, isolated Supreme Court opinions is hardly that. In fact, the Court either merely restated

concern with protecting the property interests of disabled persons.

The new guardianship statutes also granted the state the right to confine a dangerous person prior to a judicial hearing. This temporary detention was approved as a "necessity of the case."⁴⁰ Although some confusion developed as to the theoretical basis for this exercise of governmental intrusion, subsequent decisions made clear that it represented an exercise of the state's police power to prevent physical harm to either the person or to others.⁴¹ It explicitly was not an expression of any duty to promote the health of, or provide treatment to, disabled persons.

The break with the historical roots and conceptual foundation of the *parens patriae* doctrine is generally traced to the Massachusetts case of *In re Josiah Oakes*.⁴² It was there, presumably for the first time, that a court ordered confinement and care for the benefit of an individual. But this alleged extension of authority to confine a nonviolent elderly man who had married out of caste and who threatened to deplete his assets was actually consistent with the original purpose of the *parens patriae* power to protect property. The court also relied on the Commonwealth's police power as a justification for insuring Oakes' safety. It couched its allegedly novel authorization in traditional terms: a deprivation of liberty of a person considered to be mentally ill was only permitted whenever his "own safety, or that of others, require[d] that he should be restrained for a certain time, and [when] restraint [was] necessary for his restoration"⁴³ In fact, as other commentators have subsequently

the obvious, as in *Fontain v. Ravenel*, 58 U.S. (17 How.) 369, 384 (1855) ("The State, as a sovereign, is the *parens patriae*") or, in a fuller exposition of the doctrine, simply sanctioned litigation brought by the state in the name of its citizens. *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972). It is noteworthy that even this authority to initiate legal action focused on the property interests of Hawaiian citizens. *Id.*

40. *Colby*, 12 N.H. at 530 (1842); see *Developments*, *supra* note 7, at 1209 n.56. The necessity doctrine was intended as an interim measure, limited in duration and directly related to the underlying purpose for detention. *Colby*, 12 N.H. at 530-31. It is analogous to the emergency provisions of current commitment statutes. See S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 51-53 table 2.4.

41. See *Mormon Church v. United States*, 136 U.S. 1, 56-58 (1890) (power to provide protection of the person and property); see also S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 21 n.3. The government's traditional responsibility for preventing harm to its citizens, previously expressed as an exercise of its police power, had been effectively reconceived as a combination of this authority and a transposed version of the *parens patriae* doctrine. The distinction depended upon whether the threat of danger was to the disabled individual himself or to other members of the community. This confusion still exists today, albeit in a less pronounced form. See Hermann, *supra* note 19, at 95 (preventing harm to self involves both police power and *parens patriae* power).

42. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 14.

43. *Id.* (emphasis added).

noted, the case is hardly novel at all;⁴⁴ the predicate of physical danger, even if occasioned by incompetence and imprudence, was ostensibly still required.

But as the beneficent motives of caretakers proliferated and the facilities for confining people multiplied,⁴⁵ the predeterminants of civil commitment were eventually distorted beyond recognition. The concomitant conditions of physical harm and individual need were converted into alternative requirements.⁴⁶ The requisite of physical risk was enlarged to encompass any threat to a person's well-being. The king's responsibility to safeguard his incompetent subjects' financial security was transposed to a mandate to *promote* their general welfare.⁴⁷ A narrow royal obligation had become a democracy's license to fix.

From there, benevolent paternalism knew no bounds; the perversion of a protective doctrine continued unabated. Just a century later, over half a million people were civilly committed or otherwise involuntarily confined in state mental hospitals at any given time.⁴⁸ Most were deemed to be mentally ill and "in need of treatment," although few were offered the benefits promised. Vagueness of statutory definitions allowed a doctor's declaration of mental illness to be legally equated with the royal requirement of incompetence.⁴⁹ The charity of society's motives to (coercively) treat the mentally ill obscured the questionable extension of its

44. *Developments*, *supra* note 7, at 1209 n.56; see also Myers, *supra* note 9, at 380 n.62, 386 n.102. Some courts disagree, however, concluding that the case represents a major conceptual transformation of governmental power over people labeled mentally ill. *Lessard*, 349 F. Supp. at 1085.

45. *Lessard*, 349 F. Supp. at 1085. Dorothea Dix alone was responsible for the founding of 32 mental hospitals, and for the enlargement of existing institutions in 20 states. She nearly succeeded in obtaining a federal grant of over 12 million acres of land as a "reservation" for the mentally ill. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 15.

46. *Developments*, *supra* note 7, at 1210 n.57. While the court of appeals in *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973) did acknowledge in passing the possible legitimacy of committing nondangerous persons, it simultaneously cast into doubt the basis of the state's authority to confine those who pose no risk to anyone. *Id.* at 658-60. It is of some significance that the court was interpreting the constitutionality of a commitment statute which was limited to individuals who were likely to *injure* themselves or others. *Id.*

47. *In re Colah*, 3 Daly 529, 533 (N.Y.C.P. 1871) (authorizing deportation of mentally disabled Indian in order that he could return to a more temperate climate and familiar religious rituals to promote his well-being). The momentum accelerated with time. See, e.g., *Hammon v. Hill*, 228 F. 999 (W.D. Pa. 1915); *Mayock v. Martin*, 157 Conn. 56, 245 A.2d 574 (1968), *cert. denied*, 393 U.S. 1111 (1969); *In re Brown*, 151 Mont. 440, 444 P.2d 304 (1968).

48. Some figures were even higher. *Jackson v. Indiana*, 406 U.S. 715, 737 n.22 (1972) (estimates that 90% of the 800,000 patients in mental hospitals were involuntarily committed); see also *Developments*, *supra* note 7, at 1193 n.3.

49. The movement began in the early nineteenth century. *Mason*, *supra* note 38. It exploded with the advent of psychiatry and the proliferation of diagnoses. *Livermore*, *supra* note 22, at 80. For an exceptional review of the taxonomy of mental illness, see *id.* at 80 n.19.

authority. It also left unchallenged, for over a century, the dubious rationale for segregating whole classes of citizenry and the often unnoticed but omnipresent deprivations of their fundamental civil liberties.

Eventually some order was restored to the commitment process. Insightful commentators⁵⁰ and inspired lawyers focused on the dramatic extension of civil commitment and the previously unquestioned violations of constitutional guarantees.⁵¹ Substantive challenges to the standards for commitment and due process attacks on statutory mechanisms for institutionalizing people with mental disabilities produced what some labeled sweeping reforms, but which were mostly a return to historical traditions and justifications.⁵² Most notably, courts invalidated vague statutory provisions for *parens patriae* commitments and required detailed demonstrations of dangerousness as the primary, if not exclusive, method of involuntary confinement under the state's police power.⁵³ There could be no doubt that the unbridled expansion of the doctrine of *parens patriae* was finally being curbed, and that the state's authority to protect its incompetent citizens from harm was being restored to its rightful foundation.

The United States Supreme Court entered the conflict belatedly but decisively. After almost a century of silence since the states began their expansion of civil commitment, the Court provocatively noted in *Jackson v. Indiana*⁵⁴ that "[c]onsidering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this

50. Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for a Reexamination*, 51 MARQ. L. REV. 1 (1967); DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 MINN. L. REV. 1149 (1976); Morse, *supra* note 12 (arguing for abolition of involuntary commitment); Postel, *Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1 (1971); Comment, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562 (1977).

51. One commentator suggests that the law itself was a bit schizophrenic by initially delegating broad discretion and even quasi-judicial authority to physicians caring for people considered to be mentally ill, and then challenging these caretakers and their medically-oriented decisionmaking process for contravening legal norms of fairness. *Commitment in North Carolina*, *supra* note 29, at 987-89 & 987 n.10.

52. See cases cited *supra* note 30.

53. Cross v. Harris, 418 F.2d 1095, 1099-1102 (D.C. Cir. 1969) (in viewing dangerousness, the court must examine the likelihood and magnitude of possible harm); Millard v. Harris, 406 F.2d 964, 973 (D.C. Cir. 1968); Colyar, 469 F. Supp. 424 (to commit an individual under the *parens patriae* power, the state must show that the individual is: (1) mentally ill; (2) an immediate danger to himself; and (3) unable to make a rational decision regarding his treatment); Dixon v. Attorney General, 325 F. Supp. 966 (M.D. Pa. 1971). The best-reasoned and historically persuasive statement of this conclusion can be found in *Hawks*, 157 W. Va. at 427-30, 202 S.E.2d at 117-20.

54. 406 U.S. 715 (1972).

power have not been more frequently litigated.”⁵⁵ Although it initially disavowed any need to evaluate the scope of the state’s power to commit, the court voided, on equal protection and due process grounds, the indefinite institutionalization of an incompetent criminal defendant who was being held pursuant to lenient commitment standards which bore little relation to any justifiable purpose for confinement.⁵⁶

Even more significantly that term, the Court decided the first case which established the acceptable limits of a state’s authority to commit people with mental disabilities. In *Humphrey v. Cady*,⁵⁷ the Justices suggested that involuntary commitment required a “social and legal judgment that [the person’s] potential for doing harm, to himself or others, is great enough to justify such a massive curtailment of liberty.”⁵⁸ This suggestion was made explicit three years later in *O’Connor v. Donaldson*.⁵⁹ Although refusing to decide whether the provision of treatment might ever legitimize the confinement of nondangerous persons,⁶⁰ the Court left no doubt that institutionalization was certainly no benefit, in and of itself, regardless of the comparative living conditions available to the person in the community. The constitutional test to be met in confining a mentally ill person was the individual’s “ability to survive safely”⁶¹—the same standard routinely applied for centuries in England and subsequently in the colonies as the appropriate limits of the police power.⁶²

*Addington v. Texas*⁶³ was the first case in which the entire Court

55. *Id.* at 737 (footnotes omitted).

56. *Id.* at 730, 738.

57. 405 U.S. 504 (1972).

58. *Id.* at 509 (footnote omitted). Courts and commentators alike have correctly interpreted this command to preclude civil commitment of people with mental illness except upon a finding of dangerousness: *O’Connor*, 422 U.S. 563; *Suzuki v. Yuen*, 617 F.2d 173 (to justify involuntary commitment, there must be a showing that danger is imminent). This restriction applies regardless of whether confinement is sought pursuant to the police power or *parens patriae* principle. See *Developments*, *supra* note 7, at 1212, 1222. Most importantly, courts have left no doubt that these parameters are constitutionally compelled. See *Colyar*, 469 F. Supp. at 431; *Doremus*, 407 F. Supp. at 514-15; see also cases cited *supra* note 30; *Dix*, *supra* note 22, at 140-49; *Morse*, *supra* note 12, at 76-78.

59. 422 U.S. 563 (1975).

60. *Id.* at 575.

61. *Id.* at 575-76. Only one member of the unanimous Court felt constrained to even mention the term *parens patriae*. *Id.* at 578 (Burger, C.J., concurring). Even the Chief Justice, in challenging the then emerging concept of a constitutional right to treatment, emphatically stated: “[T]he existence of some due process limitations on the *parens patriae* power does not justify the further conclusion that it may be exercised to confine a mentally ill person only if the purpose of the confinement is treatment.” *Id.* at 583-84.

62. See *supra* text accompanying notes 22-27.

63. 441 U.S. 418 (1979).

validated the *parens patriae* authority as a justification to detain disabled persons. Chief Justice Burger, in writing the majority opinion, made clear that protecting an individual from physical harm to himself is a legitimate exercise of that power.⁶⁴ But even this rationale for state intervention was not novel; it merely reflected the gradual shift in the conceptual categorization of danger to self, from the police to the *parens patriae* power. The limits of those powers, at least taken collectively, remained intact.

Federal courts intervened in response to the doctrinal distortions and excessive exercise of the state's authority to involuntarily institutionalize people labeled mentally ill. The beneficent purposes underlying the *parens patriae* power had perverted its appropriate constraints.⁶⁵ The legal limits imposed were less a "full retreat"⁶⁶ than a return to the original justification for the power—the state's responsibility to protect its incompetent citizens from physical harm.

Not everyone appreciated this righting of the balance or return to historical roots.⁶⁷ But legislatures either anticipated or followed the instructions of federal courts and uniformly revised their commitment laws to reflect these restrictions on the state's authority to confine people with disabilities.⁶⁸ Psychiatrists deplored the criminalization of civil commitment, both in terms of the adoption of analagous procedures and the

64. *Id.* at 426. This reference, however, was preceded by the Court's statement that "it is indisputable that involuntary commitment to a mental hospital *after a finding of probable dangerousness to self or others* can engender adverse social consequences to the individual." *Id.* at 425-26 (emphasis added). When read in this context, it is clear that the full Court was not endorsing any return to the benign paternalism and attendant excesses of the past 100 years. On the contrary, it was reaffirming that confinement and involuntary treatment were constitutionally acceptable only to prevent physical harm to disabled persons or others in the community. See *O'Connor*, 422 U.S. at 574 n.9.

65. See A. DEUTSCH, *THE SHAME OF THE STATES* 40-96 (1948); see also *Quesnell v. State*, 83 Wash. 2d 224, 517 P.2d 568 (1973) (en banc); *Morse*, *supra* note 12, at 88 n.146; *Developments*, *supra* note 7, at 1221, 1228. Institutional wards overflowed with disabled persons who neither required hospital treatment nor received it. *O'Connor*, 422 U.S. at 569; *Wyatt v. Stickney*, 325 F. Supp. 781, 784-85 (M.D. Ala. 1971), *aff'd sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

66. *Hawks*, 157 W. Va. at 432, 202 S.E.2d at 120.

67. It is naive at best for some commentators to recite the history of the abuse of the *parens patriae* power during the first half of this century, replete with references to institutional warehousing and socially sanctioned segregation, and then recommend its revitalization through an expanded authority to involuntarily commit to community clinics those who might benefit from psychiatric interventions. See *Myers*, *supra* note 9, at 409-11 (the shortcomings of deinstitutionalization are exacerbated by involuntary commitment laws); see also *Hermann*, *supra* note 19; *Commitment in North Carolina*, *supra* note 29.

68. Most states now limit civil commitment to individuals considered to have a mental illness who are dangerous to themselves or others. For a list of these jurisdictions, see *La Fond*, *supra* note 22, at 499 n.4; see also S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at

narrowing of the substantive criteria to potentially "dangerous individuals."⁶⁹ Mental health professionals and critics claimed alarm at the release of persons who, although usually capable of caring for their basic needs, were sometimes disoriented and occasionally crazy.⁷⁰

Related but distinct social policies—notably deinstitutionalization and community mental health care—were also enveloped into the transformation of the civil commitment process. These policies were subsequently blamed for the natural and probable consequences of the legal rebalance.⁷¹ New proposals for restoring the *parens patriae* authority as the centerpiece of state commitment schemes emerged.⁷² They were advocated by psychiatrists, local public officials, and parents of young adults who could no longer be institutionalized and were less than enthusiastic about psychiatric prescriptions for treatment in the community. Against this background, outpatient commitment has been heralded as

114-19 table 2.6; S. HERR, S. ARONS & R. WALLACE, *LEGAL RIGHTS AND MENTAL HEALTH CARE* (1983); Hermann, *supra* note 19, at 94 & n.60.

69. Abramson, *The Criminalization of Mentally Disordered Behavior*, 23 *HOSP. & COMMUNITY PSYCHIATRY* 101, 103 (1972); see *Commitment in North Carolina*, *supra* note 29, at 991; Slovenko, *Criminal Justice Procedures in Civil Commitment*, 28 *HOSP. & COMMUNITY PSYCHIATRY* 817 (1977).

70. These clinicians appear to have a preoccupation with the lethal effect of the Bill of Rights. See, e.g., Appelbaum & Gutheil, "Rotting With Their Rights On": *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 *BULL. AM. ACAD. PSYCHIATRY AND THE L.* 306 (1978); *Commitment in North Carolina*, *supra* note 29, at 992 n.30; Treffert, "Dying With Their Rights On," 130 *AM. J. PSYCHIATRY* 1041 (1973). Like other institutional caretakers such as police officers and prison guards, the doomsday predictions rarely materialize.

71. Aviram & Segal, *Exclusion of the Mentally Ill*, 29 *ARCHIVES OF GEN. PSYCHIATRY* 126 (1973); Myers, *supra* note 9, at 409; Talbott, *Deinstitutionalization: Avoiding the Disasters of the Past*, 30 *HOSP. & COMMUNITY PSYCHIATRY* 621 (1979). Some critics of the sensible reforms of the past two decades would attribute America's housing shortage and its resultant homelessness crisis to the reaffirmation by the Supreme Court, lower federal courts and state legislatures of the dangerousness standard for civil commitment. Hermann, *supra* note 19, at 83-84. The National Center for State Courts takes a more reasoned view concerning the relationship between commitment laws and deinstitutionalization. See *COMMITMENT GUIDELINES*, *supra* note 11, at 494.

72. A. STONE, *MENTAL HEALTH AND THE LAW: A SYSTEM IN TRANSITION* 65-70 (1975); Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 *AM. J. PSYCHIATRY* 1121 (1979); see Chodoff, *supra* note 17. For a critical and convincing analysis of these proposals, see Morse, *supra* note 12, at 87-93. There is also substantial doubt whether the recommended changes would achieve their goals or, in fact, make any difference at all. See *Commitment in North Carolina*, *supra* note 29, at 999-1002; Monahan, Ruggiero & Friedlander, *Stone-Roth Model of Civil Commitment and the California Dangerousness Standard*, 39 *ARCHIVES OF GEN. PSYCHIATRY* 1267 (1982); Pierce, Durham & Fisher, *The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals*, 142 *AM. J. PSYCHIATRY* 104 (1985).

the constitutionally acceptable compromise.⁷³

B. Outpatient Commitment

Outpatient commitment, in its simplest form, is designed to ensure that treatment is accepted by nondangerous and presumptively capable persons who can live safely in community settings. It is therefore not an exercise of governmental power to protect incompetent individuals who pose a serious physical threat to themselves; rather it is an expression of the much enlarged authority which developed over the past century to promote the health or interests of persons considered to be mentally infirmed. Even if it were restricted to those actually incapable of rendering informed treatment decisions, the concept nevertheless represents a return to the state-sanctioned restriction of nondangerous persons in order to further their supposed interests. This expanded exercise of the *parens patriae* power has recently been cast into disrepute.⁷⁴ Thus, the legal justification for outpatient commitment depends either on a narrowing of its application to dangerous people who clearly may be subjected to involuntary psychiatric care, or on a showing of a separate governmental interest for compelling treatment in the community rather than imposing institutionalization.⁷⁵

Limiting coerced community care to those dangerous mentally ill individuals who otherwise would be civilly committed to an inpatient facility might be immune from constitutional challenge but is politically unacceptable and practically unfeasible.⁷⁶ Requiring individuals who pose a substantial risk of harm to themselves or others to participate in a community mental health program as a dispositional option to involuntary hospitalization is an interesting and arguably compelling application of the least restrictive alternative principle.⁷⁷ But this is hardly what is commonly understood as the proper scope or popular application of outpatient commitment. In fact, when so applied, it apparently has been of

73. COMMITMENT GUIDELINES, *supra* note 11, at 77-81; Myers, *supra* note 9, at 418-20; Hermann, *supra* note 17, at 100-03.

74. O'Connor v. Donaldson, 422 U.S. 563, 576 (1975); Colyar v. Third Judicial Dist. Ct., 469 F. Supp. 424 (D. Utah 1979); see Dix, *supra* note 22, at 140; *Developments*, *supra* note 7, at 1221.

75. A five year research project by the National Center for State Courts and its National Task Force on Guidelines for Involuntary Civil Commitment concluded that community services should be provided with the person's consent. COMMITMENT GUIDELINES, *supra* note 11, at 457, 460, 473, 483 (Guidelines D6, D8, E5, F5).

76. See *infra* text accompanying notes 252-56.

77. See *infra* notes 83-129 and accompanying text for a discussion of the least restrictive alternative principle.

little utility or significance.⁷⁸

Alternatively, all civil commitment could be broadened to include those who are not now within the scope of the state's police power or a proper interpretation of its *parens patriae* authority—individuals who pose no present danger to themselves or others but who, in the judgment of mental health workers, would benefit from psychiatric treatment or deteriorate in its absence.⁷⁹ These individuals are less threatening to local sensibilities and therefore generally would be considered appropriate candidates for community mental health care. However, this approach inevitably involves a significant expansion of civil commitment criteria, which has little support in judicial decisions and directly contravenes the constitutional parameters of coerced treatment.

A third alternative has been proposed: maintain the more restrictive criteria for involuntary institutionalization mandated by the courts and incorporated in most statutory schemes, but create a more encompassing standard just for outpatient commitment.⁸⁰ A few states have experimented with this approach.⁸¹ It does address the practical constraints of ensuring that only competent, compliant and nonthreatening persons are committed to community programs without sanctioning the incarceration of those who are not dangerous. But it ignores the fundamental limitations on the state's *parens patriae* authority to restrict the freedom of any of its citizens which has been so widely abused in the recent past. It simultaneously establishes a dual standard for the deprivation of fundamental liberties for reasons which hardly seem compelling.⁸²

Regardless of allegedly humane motivations, outpatient commitment proposals which sanction the involuntary treatment of competent persons who do not pose any immediate risk to their own physical safety, solely to improve their mental health, face substantial constitutional and theoretical difficulties. They simply are not consistent with the legal

78. The conclusions of a detailed study in North Carolina before and after the passage of a new outpatient commitment law are revealing. The authors determined that despite the availability of a statute permitting compulsory community treatment in lieu of involuntary institutionalization, little use was made of this new procedure. A major reason given by respondents to a survey was that those who were properly commitable were too dangerous to live in an unstructured community setting. *Commitment in North Carolina, supra* note 29, at 1009-13 & n.114. The authors concluded that: "Overall, the statutory changes did not seem to have made a significant difference in the use of outpatient commitment." *Id.* at 1013.

79. *See supra* note 72.

80. *See Hermann, supra* note 19, at 100-03; Myers, *supra* note 9, at 418-20.

81. *See supra* note 20.

82. This distinction faces serious constitutional difficulties similar to those which required the invalidation of commitment statutes by the Supreme Court in *Jackson v. Indiana*, 406 U.S. 715, 730 (1972), and *Baxstrom v. Herold*, 383 U.S. 107 (1966).

foundation on which they purport to rest. On the contrary, they represent a significant distortion of the historical purpose and benign motivation of the *parens patriae* principle.

III. THE DOCTRINE OF THE LEAST RESTRICTIVE ALTERNATIVE

There is no independent right to live in a particular place. Despite the frequent use of the popular phrase "least restrictive alternative,"⁸³ people labelled as mentally ill do not possess, by virtue of either their citizenship or their disability, a constitutional entitlement to live in a specific environment or neighborhood. They do, however, have a compelling claim not to be deprived of their fundamental liberties except under narrowly tailored circumstances.⁸⁴ The doctrine of the least restrictive alternative, as applied to the civil commitment process, requires a consideration of noninstitutional options to the involuntary hospitalization of people with mental handicaps.⁸⁵

83. The term "least drastic means" has its historical roots in the Supreme Court's constitutional adjudication. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960); see, e.g., *Less Drastic Means and the First Amendment*, 78 YALE L.J. 464 (1969). For a fascinating and scholarly account of this tradition, see Wormuth & Mirkin, *The Doctrine of the Reasonable Alternative*, 9 UTAH L. REV. 254 (1964). The term "principle of the least restrictive alternative" was first presented in the mental health literature by Professor David Chambers in his seminal article, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1111 n.9 (1972). Chambers expressed his gratitude to the Supreme Court for not succumbing to "catchy phrase[s]." *Id.* at 1111 n.9; see also O'Connor v. Donaldson, 422 U.S. 563, 575-76 (1975).

84. *Jackson v. Indiana*, 406 U.S. 715, 730 (1972) (equal protection clause prohibits different commitment standard for persons declared incompetent to stand trial). Of course, this is the same protection afforded all citizens. People with disabilities simply are singled out for special restrictions in special places for reasons which are historically and constitutionally suspect. See *supra* Part II of this Article; *City of Cleburne v. Cleburne Living Center*, 105 S. Ct. 3249, 3266-68 (1985) (Marshall, J., concurring in part and dissenting in part); see generally Morse, *supra* note 12.

85. There is no unified definition of the principle or established standards for its application. The Supreme Court implicitly suggested a straightforward test: living independently or with the help of family or friends. *O'Connor*, 422 U.S. at 575. Other courts have proposed a wider range of possibilities including identification cards, public nursing care, community mental health and day care services, foster care, home health aides and other support services. *Lake v. Cameron*, 364 F.2d 657, 661 (D.C. Cir. 1966). Commentators have documented a still more varied range of options. See Chambers, *supra* note 83, at 1112-19; Stein & Test, *Alternative to Mental Hospital Treatment*, 37 ARCHIVES OF GEN. PSYCHIATRY 392 (1980). Finally, national panels of experts have attempted, with questionable success, to identify the elements which should be used to apply the principle. The Institute on Mental Disability and the Law and the National Center for State Courts settled on the following nine factors to consider in balancing the interests of the individual and the state:

- (1) THE environmental restrictiveness of the treatment setting (e.g., inpatient hospital, half-way house, or community mental health center);
- (2) THE psychological or physical restrictiveness of behavioral, chemical, or biological treatments;

The least drastic means principle creates no independent rights, but instead is an interpretative guideline for assessing whether an established constitutional precept has been infringed. It imposes an additional burden on the state to legitimize actions which impinge on otherwise protected privileges of citizenship. The state must demonstrate that care was given to the selection of the form and extent of the proposed intrusion on individual rights, although the level of judicial scrutiny of the means adopted may vary considerably.⁸⁶

The viability of the doctrine has depended greatly on two factors: the rights at stake and the appropriateness of judicial second-guessing of implementation options.⁸⁷ In the early part of this century, the Supreme

(3) CLINICAL variables including the respondent's behavior as it relates to the legal criteria for commitment, the relative risks and benefits of treatment alternatives, and the family and community support available in the respondent's environment;

(4) THE quality and likely effectiveness of the care and treatment;

(5) THE duration of the treatment;

(6) THE risk that a respondent may pose;

(7) THE availability, cost, and accessibility of the treatment;

(8) THE likelihood of the respondent's cooperation in or compliance with the treatment program; and

(9) THE mechanism for monitoring and reviewing a respondent's compliance with the conditions of the treatment program.

LRA REPORT, *supra* note 11, at 329-30 (emphasis deleted by author).

It is hardly obvious that these are the right nine factors or even that a balancing of questionable considerations is appropriate. Applying a method of constitutional analysis should not degenerate into a juggling act.

86. The concept itself implies a judicial role somewhat at odds with the separation of powers principle. For courts to analyze not merely the reasonableness of the objective but also the propriety of the means chosen by the legislature involves an element of substituted judgment. *Shelton*, 364 U.S. at 493-94 (Frankfurter, J., dissenting). In part, this tension is inherent in the doctrine; in part, it is a measure of the right at stake. Where economic regulation is tested under precepts of substantive due process, the subjectiveness of the constitutional concept makes speculation about desirable public policy almost inevitable. See *Schlesinger v. Wisconsin*, 270 U.S. 230, 241-42 (1926) (Holmes, J., dissenting). The tendency to second-guess legislative judgments is mitigated, however, by principles of federalism and comity, deference to professional judgment and administrative expertise, *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Carolene Prods. Co. v. United States*, 323 U.S. 18, 29 (1944), and the degree of judicial comfort in resisting governmental limitations on individual rights. *Thomas v. Collins*, 323 U.S. 516 (1945). The relevant factors are carefully explained in *Wormuth & Mirkin*, *supra* note 83, at 296-303.

87. *Wormuth & Mirkin*, *supra* note 83, at 299, acknowledge the differing views of the Justices on the relevance of these considerations, but conclude that most members of the Supreme Court apply the principle by balancing these factors. The authors' summary two decades ago holds equally true today:

When a constitutional order specifies the objectives of legislative power—health, safety, welfare, morals, let us say—it prescribes some of the values to which the society is dedicated. When the constitutional order guarantees certain rights—liberty, property, freedom of speech and religion, jury trial—it prescribes additional values. The world being what it is, collisions of values are inevitable. The doctrine of the reasonable alternative is a technique for the adjustment of such collisions. When

Court relied heavily upon the concept of the least drastic means to void legislation under the commerce clause.⁸⁸ Where freedom of contract was at stake, the anti-regulationists on the Court could always find a better means for accomplishing a legislative goal than the one chosen. Not surprisingly, this judicial frustration of the representative process did little to commend the doctrine to a less elitist Court. As notions of substantive due process in the area of economic regulation fell into disfavor, so did least restrictive analysis.⁸⁹

The doctrine was revived, and perhaps found a permanent home, in the emergence of first amendment jurisprudence during the 1920's and 1930's.⁹⁰ By limiting the judicial choice of means as well as ends to the central guarantees of citizenship—which later would be termed fundamental freedoms—the principle was restored to a position of respectability. This culminated in the classic statement of the principle by the Court in *Shelton v. Tucker*:⁹¹

[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.⁹²

With less vigor and greater unpredictability, the Court occasionally invoked the doctrine in procedural due process cases.⁹³ It then gained a firm hold in the substantive due process arena, at least when fundamental rights such as association,⁹⁴ freedom from bodily restraint,⁹⁵ travel,⁹⁶

it is available, it preserves both of the conflicting values and maintains the integrity of the constitutional order.

Id. at 305.

88. *See id.* at 263-66.

89. *Olsen v. Nebraska ex rel. W. Reference & Bond Ass'n*, 313 U.S. 236 (1941), explicitly overruled *Ribnik v. McBride*, 277 U.S. 350 (1928), the last in a line of alternative means cases in the economic regulation area. *See Wormuth & Mirkin, supra* note 83, at 266.

90. *Winters v. New York*, 333 U.S. 507 (1948); *Martin v. City of Struthers*, 319 U.S. 141 (1943); *Schneider v. New Jersey*, 308 U.S. 147, 164 (1939); *Lovell v. Griffin*, 303 U.S. 444, 447 (1938); *Near v. Minnesota*, 283 U.S. 697 (1931); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Myer v. Nebraska*, 262 U.S. 390 (1923).

91. 364 U.S. 479.

92. *Id.* at 488 (footnotes omitted).

93. *See Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950); *see also Wormuth & Mirkin, supra* note 83, at 293-96.

94. *See NAACP v. Button*, 371 U.S. 415, 433-36 (1963); *Talley v. California*, 362 U.S. 60, 67 (1960). *But see Members of the City Council v. Taxpayers for Vincent*, 466 U.S. 789, 808-12 (1984).

95. *See O'Connor*, 422 U.S. at 580; *McNeil v. Director*, 407 U.S. 245, 248-50 (1972); *Ex Parte Endo*, 323 U.S. 283, 300-02 (1944).

voting⁹⁷ and privacy⁹⁸ were threatened. By the time the Court belatedly acknowledged the plight of people with mental disabilities and the sordid history of their confinement,⁹⁹ the application of a principle mandating legislative care and governmental restraint came as a natural extension to the articulation of their basic rights of citizenship.

The trend began in the nation's capital where the federal court applies local law to commit people with mental disabilities to a federal institution. This unique arrangement was an obvious forum for the application of flourishing procedural safeguards to new beneficiaries. In *Lake v. Cameron*,¹⁰⁰ the Court of Appeals for the District of Columbia Circuit took the then radical step of questioning the continued institutionalization of a harmless elderly woman in St. Elizabeth's Hospital. Chief Judge Bazelon simply wondered whether something else could be done to address the predictable consequences of the aging process: confusion, loneliness and frailty. But to accomplish the obvious involved the invocation of a concept then new to mental health law. The court, for the first time, concluded that prior to involuntary institutionalization, the government must bear the burden of demonstrating that no less restrictive alternatives are available.¹⁰¹

The implications of this humanitarian gesture on the role of the courts did not go unnoticed. There were many who were not persuaded by the logic of the evolution. The dissenters in *Lake* complained that local judges were not equipped "to initiate inquiries and direct studies of social welfare facilities or other social problems."¹⁰² Until then, the least drastic means doctrine had been limited to a standard for evaluating the

96. See *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 268-69 (1974); *Vlandis v. Kline*, 412 U.S. 441, 451 (1973); *Shapiro v. Thompson*, 394 U.S. 618, 634, 637 (1969); *Aptheker v. Secretary of State*, 378 U.S. 500, 507 (1964).

97. *O'Brien v. Skinner*, 414 U.S. 524, 534 (1974) (Marshall, J., concurring); *Dunn v. Blumstein*, 405 U.S. 330, 342, 353 (1972).

98. See *Thornburgh v. American College of Obstetricians and Gynecologists*, 106 S. Ct. 2169 (1986); *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632, 644-46 (1974).

99. See *City of Cleburne*, 105 S. Ct. at 3272 (Marshall, J., concurring in part and dissenting in part); *O'Connor*, 422 U.S. at 573-74; *Jackson*, 406 U.S. at 737; *Baxstrom v. Herold*, 383 U.S. 107 (1966).

100. 364 F.2d 657 (D.C. Cir. 1966).

101. *Id.* at 661. The court's list of possible alternatives reflected a preference for voluntary services: "Every effort should be made to find a course of treatment which appellant might be willing to accept." *Id.* But it apparently was willing to tolerate some element of coercion: "The court may consider . . . whether she should be required to accept public health nursing care . . ." *Id.* Judge Wright rejected this latter caveat: "I cannot accept the proposition that this showing automatically entitles the Government to compel Mrs. Lake to accept its help at the price of her freedom." *Id.* at 662-63 (Wright, J., concurring).

102. *Id.* at 663 (Burger, J., dissenting). This may have been one of the initial expressions of the Chief Justice's hostility toward the rights of people with mental illness. See *O'Connor*, 422

acceptability of legislative choices concerning restrictions on the constitutional rights of the entire citizenry, or at least a significant portion thereof. It had never been applied on a case by case basis to individual deprivations. Rather than reviewing legislative judgments, the Bazelon approach obliged commitment courts to repeatedly analyze clinical recommendations for each person the government sought to confine in order to determine which amongst several would be the least intrusive.¹⁰³ The constitutional foundation for extending the least restrictive principle to civil commitment may have been unassailable, but the process for its application certainly was not.

The conceptual correctness of the majority's view prevailed. It appeared to be a long leap from an Arkansas teacher's affiliation requirement to the involuntary hospitalization of people with mental illness when a commentator first suggested that least restrictive analysis was an essential component of civil commitment schemes.¹⁰⁴ But soon there was virtual unanimity among the lower courts that mentally disabled citizens could be validly committed only if there was no less restrictive means which would serve the state's interests in protecting the person or the community from harm.

What began as a review of individual confinement decisions soon exploded into wholesale challenges to the entire commitment statute. In *Covington v. Harris*,¹⁰⁵ the Court of Appeals for the District of Columbia Circuit first applied the concept to ward assignments *within* a mental hospital.¹⁰⁶ Soon the idea spread.¹⁰⁷ Frontal attacks on the commitment statutes themselves, based upon the absence of a requirement to consider

U.S. at 578, 582 (Burger, C.J., concurring); see also *Parham v. J.R.*, 442 U.S. 584, 601 (1979); *Addington v. Texas*, 441 U.S. 418, 429 (1979).

103. This methodology is not consistent with the historical application of the doctrine. See *Wormuth & Mirkin*, *supra* note 83, at 254-55, 305. But it is not the principle which is distorted by a shift from assessing the rationality of legislative judgments to evaluating the merits of institutional alternatives; it is the extent to which this inquiry enmeshes the courts in clinical considerations—an area the Supreme Court has steadfastly refused to enter. See *Youngberg*, 457 U.S. at 321; *Parham*, 442 U.S. at 607-08; see also *infra* text accompanying notes 266-74. This quagmire can be skirted by limiting the analysis to the tension between the government's responsibility to protect the safety of the community and the classic constitutional values of personal liberty, physical freedom and individual choice.

104. The original article incorporating that creative observation has become the hallmark for understanding the principle in the context of the involuntary institutionalization of people with mental handicaps. Chambers, *supra* note 83. It is as delightful to read as it is provocative, although some of its conclusions seem unduly hesitant and deferential today. *Id.* at 1187.

105. 419 F.2d 617 (D.C. Cir. 1969).

106. *Id.* at 623-25.

107. See *United States v. Ecker*, 543 F.2d 178 (D.C. Cir. 1976); *Eubanks v. Clarke*, 434 F. Supp. 1022, 1027 (E.D. Pa. 1977); *In re Jones*, 338 F. Supp. 428 (D.D.C. 1972); *In re Kesselbrenner*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973).

alternatives to institutionalization, represented a significant expansion of the doctrine.¹⁰⁸ The measure of restrictiveness became an essential calculus in the process and, in many states, one of the required findings necessary to sustain involuntary hospitalization.

Although never explicitly discussing the doctrine, the Supreme Court offered its tacit endorsement to the movement. At the outset it cautioned that "the *nature* and duration of commitment [must] bear some reasonable relation to the purpose for which the individual is committed."¹⁰⁹ Three years later, it invalidated the confinement "of those capable of surviving safely in freedom, on their own or with the help of family or friends,"¹¹⁰ citing the doctrine's constitutional flagship, *Shelton v. Tucker*.¹¹¹ The signal was not lost on the states. Either on their own initiative early in the evolution or at the insistence of federal courts later on, almost every legislature revised its civil commitment statute to require a review of alternatives to involuntary hospitalization.¹¹² Even if these provisions were vague, leaving unanswered many issues such as the burden of proof and the criteria for assessing restrictiveness, they left no doubt about the doctrine's arrival.¹¹³

108. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on procedural grounds*, 414 U.S. 473 (1974), *reinstated*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *reaff'd*, 413 F. Supp. 1318 (E.D. Wis. 1976); *see also* *Stamus v. Leonhardt*, 414 F. Supp. 439 (S.D. Iowa 1976); *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Haw. 1976), *modified sub nom. Suzuki v. Yuen*, 438 F. Supp. 1106 (D. Haw. 1977), *aff'd in part and rev'd in part*, 617 F.2d 173 (9th Cir. 1980); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Dixon v. Attorney Gen.*, 325 F. Supp. 966 (M.D. Pa. 1971); *Gallup v. Alden*, 57 Mass. App. Dec. 41 (1975).

109. *Jackson*, 406 U.S. at 738 (emphasis added).

110. *O'Connor*, 422 U.S. at 575.

111. 364 U.S. 479. *See id.* at 488-90.

112. A survey of all the states revealed that by 1972, 17 jurisdictions had statutes including some reference to the provision of treatment in the least restrictive alternative. In 1977, this number had increased to 35. As of 1982, it was 47, leaving only Alabama, Mississippi and Oregon without some mention of the doctrine. *See* Lyon, Levine & Zusman, *Patients' Bills of Rights: A Survey of State Statutes*, 6 MENTAL DISABILITY L. REP. 178, 181-83 table 1 (1982) (extent of compliance with Bill of Rights Section of Mental Health Systems Act). A more recent survey focusing on the narrower issue of a statutory mandate to consider less restrictive alternatives to involuntary hospitalization found 39 states with such a provision. The other 12 jurisdictions permit, but do not require, this review. Keilitz, Conn & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 ST. LOUIS U.L.J. 691, 709 n.101 (1985) [hereinafter Keilitz]. For a comparison of all the states' laws, *see infra* Appendix.

113. The ambiguity of the legislative language and the uncertainty of its application have led many to wonder what the principle really means in practice. Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977); Keilitz, *supra* note 112. From the outset there has been substantial consensus that the hospital or government has the responsibility to investigate community alternatives and present them to the court or administrative body authorized to commit. *Lake*, 364

The obstacle to translating the theory's promise into practice was not the legal niceties of its application but the glaring absence of real alternatives to state institutions. So impressive was the principle that the next predictable step was to convert it into a justification for the establishment of community services. Originally suggested as the radical outstation of the doctrine which would transform an interpretive guideline into a constitutional mandate for resource reallocation,¹¹⁴ suits to compel the creation of alternative programs proliferated.¹¹⁵ Even repeated rebuffs from the Supreme Court could not undermine the momentum of the effort, which left at least those jurisdictions under suit with a substantial complement of community services.¹¹⁶

This sanguine acceptance of the principle in the civil commitment context lacks a more searching inquiry into the precise rights which are at stake. Courts often evidence a concern that *treatment* is provided in the least restrictive alternative, suggesting that clinical considerations of

F.2d at 662; Chambers, *supra* note 83, at 1168. There has been less agreement on allocating the burden of persuasion. Hoffman & Foust, *supra*, at 1118. There is no consensus on the court's responsibility to reach out on its own initiative to discover appropriate community facilities. Compare the narrow approach advocated by one member of the panel in *Lake*, 364 F.2d at 663 (Burger, J., dissenting), with several proposals offered by Chambers, *supra* note 83, at 1172-77.

What is universally understood by all observers is that the implementation of the principle in different states is inconsistent, illogical and invisible. A survey of judges in Virginia showed little comprehension of statutory provisions concerning noninstitutional alternatives, not much sympathy with the option for many classes of people, and very limited utilization of it in practice. Hoffman & Foust, *supra*, at 1124-38. A North Carolina study produced even more disappointing results. *Commitment in North Carolina*, *supra* note 29, at 999-1002. Data like this causes one to wonder whether lengthy articles like this are really necessary.

114. Chambers appears to be the first to have argued for the principle as a source of the state's obligation to fund noninstitutional services. Chambers, *supra* note 83, at 1189-95. Others disagree about both the constitutionality and wisdom of this strategy. See *Developments*, *supra* note 7, at 1252-53.

115. Cautionary notes concerning the proper function of the federal judiciary were ignored and the litigation movement was on. Within five years, federal court orders and consent decrees embraced not only the principle but also the mandate. *Halderman v. Pennhurst State School & Hosp.*, 446 F. Supp. 1295 (E.D. Pa. 1977), *modified*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981), *on remand*, 673 F.2d 647 (3d Cir. 1982), *rev'd*, 465 U.S. 89 (1984), *on remand*, 610 F. Supp. 1221 (E.D. Pa. 1985) (settlement agreement); *Gary W. v. Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976); *Davis v. Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974); *New York State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973); *Horacek v. Exon*, 357 F. Supp. 71 (D. Neb. 1973); *Wyatt v. Stickney*, 334 F. Supp. 1341 (M.D. Ala. 1971); *Brewster v. Dukakis*, No. 76-4423-F (E.D. Mass. Dec. 6, 1978) (final consent decree), *reprinted in* 3 MENTAL DISABILITY L. REP. 45 (1979), *enforced*, 544 F. Supp. 1069 (D. Mass. 1982), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986). *But see* *Garrity v. Gallen*, 522 F. Supp. 171 (D.N.H. 1981).

116. For a recent survey of community services cases, see 5 MENTAL DISABILITY L. REP. 142-43 (1981); see also Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 RUTGERS L.J. 595, 598 n.12 (1983).

the type and place of care, rather than a legal analysis of the constraints on liberty, should guide their conclusions. Two faulty assumptions underly this proposition. First, the development of a nascent right to treatment, as part of institutional reform litigation in the early 1970's, grafted the least restrictive alternative principle onto this infant entitlement in order to dictate the locus of service provision.¹¹⁷ Subsequently, substantial doubt was cast over the existence of this treatment right, at least as originally conceived under the *quid pro quo* theory of commitment and especially as an independent constitutional mandate.¹¹⁸ Even reformulated as a corollary of the fourteenth amendment's guarantee of liberty, the parameters of a right to treatment are vague, leaving the least restrictive alternative doctrine attached to a tenuous foundation.¹¹⁹

More importantly, since the purpose of the right to treatment is to ensure that institutionalized persons are provided minimally adequate psychiatric care, the doctrine has little logical application to an analysis of this mandate. It is the existence of professionally acceptable treatment which the due process clause mandates. The clinical means and locus chosen to provide the treatment are of little constitutional relevance,¹²⁰ even if they are matters properly cognizable by the courts.¹²¹

117. The right was first articulated in *Wyatt*, 325 F. Supp. at 784. The court grounded the entitlement in the due process clause of the fourteenth amendment. It held that the government must offer professionally adequate treatment to those it confines under its *parens patriae* authority, given its singular legitimate purpose of providing care to disabled persons, and under its police power, in light of the absence of procedural due process. *Id.* at 784-85. Other courts followed its lead but not its reasoning. In *Rockefeller*, the guarantee was a consequence of the right to be free from harm. 357 F. Supp. at 764. In *Welsch*, it was premised on the eighth amendment's prohibition against cruel and unusual punishment as well as on the fourteenth amendment's due process clause. 373 F. Supp. at 499, 502-03. But even if the right's constitutional foundation is shaky, its appeal to clinicians certainly is not. See *Commitment in North Carolina*, *supra* note 29, at 1022 n.143 (mental health professionals feel strongly that there should be a right to treatment).

118. See *O'Connor*, 422 U.S. at 582-83 (Burger, C.J., concurring). Despite a unanimous opinion which he joined, the Chief Justice went out of his way to attack the right and its rationale, as well as the continued viability of the lower court's opinion. *Id.* at 580.

119. When the Supreme Court finally recognized a constitutional right to some degree of care for people with retardation, it had difficulty defining the state's obligation. *Youngberg*, 457 U.S. 307. The majority went no further than necessary, restricting the entitlement to only that habilitation necessary to enable institutionalized residents to be safe, to be free from physical restraint and to exercise other freedoms. *Id.* at 318-19. But it left open the possibility for a more expansive interpretation of their liberty interests. *Id.* Three concurring justices (Blackmun, Brennan and O'Connor) would have enlarged the right to protect people with disabilities against deterioration and guarantee them the fulfillment of the state's statutory purposes for confinement. *Id.* at 326-28 (Blackmun, J., concurring).

120. A more coherent approach would focus on needed treatment: "Instead of the least restrictive alternative, the committing authority should aim at identifying the most effective treatment alternative." Hermann, *supra* note 19, at 105.

121. A claim to state-funded services is currently limited to institutionalized persons whose

The second erroneous assumption results from the wholesale transposition of the least drastic means principle to the area of mental health. As the doctrine's resurgence in constitutional jurisprudence was peaking almost two decades ago, mental health and retardation policy was in the throes of a fundamental transformation. A series of technological developments resulted in legislative proposals to create community programs as an alternative to public institutions.¹²² These new services were touted as more effective, more humane, less costly, and less restrictive. The convergence of constitutional doctrine and social policy was quickly and quietly accomplished. The talisman of least restrictiveness was soon invoked as the legal mandate for community services. It was not long before the least drastic means analysis was converted in some jurisdictions to a clinical setting determination; the issue there was no longer the standards or the methods selected as the proper measure of civil commitment, but rather the place where involuntary treatment would occur.¹²³

Not every state fell victim to this conceptual difficulty. In fact, where well-intended motives were not translated into broad extensions of the *parens patriae* authority and did not serve as the legitimization of an undefined obligation to treat, the principle of the least restrictive alternative remained true to its constitutional purposes. In these jurisdictions, the interpretive guideline was properly applied to the most basic right implicated by civil commitment—liberty.¹²⁴ Liberty could be measured

liberty has been circumscribed. Although distinctions concerning legal status (voluntary versus involuntary) may not be determinative, *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1246 (2d Cir. 1984), confinement is usually a precondition for the government's obligation to treat. See *Youngberg*, 457 U.S. at 317. But see *Thomas S. v. Morrow*, 781 F.2d 367, 374 (4th Cir. 1986) (state of North Carolina was responsible for providing treatment for young, incompetent adult who had been ward of state from birth, even though he had been released from state hospital).

A Supreme Court apparently enamoured by the wisdom of psychiatric judgments has repeatedly warned lower courts that they must defer to the experts. See *Youngberg*, 457 U.S. at 321-23; *Vitek v. Jones*, 445 U.S. 480, 499 (1980) (Powell, J., concurring); *Parham*, 442 U.S. at 607.

122. See *supra* text accompanying notes 8-10. These new approaches to mental health care mirrored, or were subsumed within, the legal principle of least drastic means. Keilitz, *supra* note 112, at 697-700. As one commentator has noted: "[I]t is likely that the application of deinstitutionalization overlaps considerably with the application of the least restrictive alternative doctrine." *Id.* at 698 n.31.

123. This was always true in those jurisdictions such as Texas, Oklahoma, the District of Columbia and others whose statutes authorized commitment to community programs. It became even more evident in states which revised their procedures explicitly to encourage outpatient commitment, based upon a lower standard than that governing institutionalization. See states listed *supra* note 20 and *infra* Appendix.

124. See *Commonwealth v. Nassar*, 380 Mass. 908, 406 N.E.2d 1286 (1980). In fact, an argument has been made that for commitment undertaken pursuant to the *parens patriae* power, the doctrine has no effect, the only issue being whether acceptable standards for con-

in several dimensions but physical freedom and the fundamental right to control one's body were clearly the most relevant criteria. The least restrictive alternative doctrine was then properly a measure of the extent of freedom restricted by state action. Coerced psychiatric treatment, no matter where compelled, implied a "massive curtailment of liberty."¹²⁵ Conversely, truly voluntary care was undoubtedly the least restrictive means for offering help. The ability to choose, not the geographic location of forcibly imposed treatment, was the proper determinant of the doctrine.

Focusing on liberty is not the only possible criteria for assessing the least drastic means for achieving governmental objectives. As noted earlier, the questionable rooting of the principle in a constitutional guarantee of treatment for involuntarily institutionalized persons would arguably implicate the *type* of clinical interventions permitted. Others have suggested that the *effectiveness* of the treatment techniques should be the primary standard, with minimal if any attention paid to the consequential curtailment of physical freedom.¹²⁶ This approach relies heavily on the assumption of an expanded *parens patriae* interest in promoting the mental health of the citizenry and a concomitant individual entitlement to high quality and effective, as opposed to minimally adequate, treatment. A guideline for constitutional analysis would become a prescription for psychiatric intrusion, with medical standards of improvement becoming the measure of the full implementation of the principle.

A third alternative would establish a complex balancing between effective treatment modalities and the least drastic of the most promising options. Not surprisingly, there are various views on the relevant criteria for assessing the restrictiveness of different forms of mental health care.¹²⁷ Consensus is not only elusive but impossible. The sheer number

finement (incapacity and harm to self) are sufficiently satisfied to justify the resultant deprivation of liberty. *Developments*, *supra* note 7, at 1248-49.

125. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972); *Lynch v. Maher*, 507 F. Supp. 1268, 1277 (D. Conn. 1981).

126. Predictably, this proposal was from psychiatrists. Chodoff, *supra* note 17, at 498-99; Hoffman & Foust, *supra* note 113, at 1144; *Commitment in North Carolina*, *supra* note 29, at 1021-22; Stromberg & Stone, *supra* note 17, at 293. Some academics have been persuaded. See Hermann, *supra* note 19, at 103-05; Myers, *supra* note 9, at 422. Interestingly, the Stone and Stromberg model, which was adopted by the American Psychiatric Association in 1982, explicitly omits any procedure for judicial commitment to community programs. What some see as its noticeable weakness, Myers, *supra* note 9, at 418 n.265, may be its finest attribute.

127. The Institute on Mental Disability and the Law of the National Center for State Courts has nine such criteria. See *supra* note 85. The physicians have five. Hoffman & Foust, *supra* note 113, at 1147. The professors suggest infinite possibilities. Myers, *supra* note 9, at 423. Perhaps the most sensible is the most simple: liberty. See *Developments*, *supra* note 7, at 1249.

of variables, to say nothing of their differential weighting, creates an alarming number of permutations and possible formulas. Charts and scales are often necessary to map the selection process, with medical experts guiding the judicial decisionmaking process in individual cases.¹²⁸

Ironically, many clinicians decry this notion of graduated treatment techniques that can be viewed on a scale of restrictiveness. They would abandon the entire approach, leave least drastic means analysis to the first amendment, and preserve the discretion to do what seems, in their judgment, best for any person who meets the statutory criteria for civil commitment.¹²⁹ While their arguments go too far, their challenge to the spectrum of restrictiveness is well-founded, particularly in the recognition that objective criteria for intrusiveness are a precarious proposition. For the principle of the least restrictive alternative to retain vitality in the commitment context, it should adhere to its original moorings in the substantive guarantee of liberty and be limited to a simple measurement of coerced versus voluntary care. Such an approach is not only consistent with the historical development of the doctrine as a guideline for assessing governmental limitations on fundamental freedoms (as opposed to time-limited interpretations of substantive due process); it also respects the proper role of the courts in weighing restrictions on liberty rather than evaluating the benefits of competing treatments.

From this perspective, outpatient commitment has little to do with the doctrine of the least restrictive alternative. Where courts either involuntarily confine disabled persons to mental health facilities located in the community as opposed to the grounds of a public institution, or compel compliance with a treatment plan that frequently includes the administration of psychotropic medication, the critical guarantee of liberty has been sharply curtailed. Coerced psychiatric treatment, pursuant to a judicial commitment order, is a massive curtailment of freedom, no matter

128. For a topography of restrictiveness and a road map to "wellness," see Myers, *supra* note 9, at 421. A different approach eschews the variable of physical freedom for the constant warping effect of time. Hoffman & Foust, *supra* note 113, at 1144-46. According to this view, effectiveness of treatment recedes in importance over time, as restrictiveness increases in relative value. Even the Supreme Court was confused by a much simpler calculus. *Youngberg*, 457 U.S. 307 (reversing a sliding scale of restrictiveness adopted by a majority of the Third Circuit Court of Appeals).

129. Stromberg & Stone, *supra* note 17, at 291-94; see also Gutheil, Appelbaum & Wexler, *The Inappropriateness of "Least Restrictive Alternative" Analysis for Involuntary Procedures with the Institutionalized Mentally Ill*, 11 J. PSYCHIATRY & L. 7 (1983); *Commitment in North Carolina*, *supra* note 29, at 1021 n.141. This may be one of the few critical issues on this subject where legal advocates and mental health professionals agree. See Keilitz, *supra* note 112, at 744. "[T]he demands placed on the LRA doctrine itself for a determination of a specific relationship between restrictiveness and treatment effectiveness, or for the establishment of a hierarchy of treatment restrictiveness, are unreasonable." *Id.* (footnotes omitted).

where accomplished. It is not made substantially less drastic by shifting the locus of the compulsion.

This is not to say that a case cannot be made that involuntary community treatment has certain advantages and impinges on certain rights to a somewhat lesser extent. It is arguable that confinement to a general hospital inpatient unit or a locked community residence is less isolating than institutionalization at a state hospital, although basic guarantees of communication, association, travel and privacy may be forfeited. It may be true that there is more physical freedom living in a community program which requires compliance with a detailed treatment plan than in remaining on a locked ward; however, fundamental rights of bodily integrity and choice are still drastically curtailed. But it is undoubtedly true that each occasion substantial restrictions of a person's liberty. To argue that some are more faithful expressions of the principle of the least drastic means necessarily requires the adoption of a complex spectrum of restrictiveness which integrates several dimensions: locus of the program; effectiveness of the mental health treatment as measured by the nature, intrusiveness, frequency and duration of the intervention; the relative importance of the individual's rights; and the type, extent and duration of the restriction imposed on the exercise of each right. Such a multi-variable analysis is too intricate for local courts to undertake on an individual basis. A new geometry of mental health would be needed. It would, of necessity, rely on the balance struck by the psychiatric experts who inform the judicial process. It could not escape becoming a forum for the competing values and disciplinary perspectives which underlie the very spectral dimensions. It is simply too arbitrary to be functional.

Outpatient commitment is conceivably a valid dispositional alternative to serve the state's interest in civil commitment, but it has little to do with least drastic means analysis. It is hardly a modern application of the doctrine. On the contrary, involuntary commitment to community programs can be viewed as a drastic extension of current alternatives that will work no less intrusion on the fundamental freedom of people labeled as mentally ill to be or not to be treated.

IV. THE CURRENT STATUS OF STATE LAW

Outpatient commitment, in its simplest form, is a statutory procedure which permits civil courts to compel persons labeled mentally ill to participate in mental health services in community settings.¹³⁰ The stat-

130. For related definitions, see COMMITMENT GUIDELINES, *supra* note 11, at 78-79; Miller & Fiddleman, *supra* note 17.

utory scheme usually includes a standard for determining which individuals may be subjected to compulsory care, a procedure for initially imposing and then reviewing the mandated treatment, and a description of the type of psychiatric intervention which may be ordered. A more probing investigation, however, reveals that this straightforward concept is increasingly elusive. Substantial differences exist among states which authorize outpatient commitment as to the existence and content of standards and procedures.¹³¹ Commentators disagree whether statutes, which merely permit a court to select a community program rather than an institution as the dispositional alternative for civil commitment satisfy the definition of true outpatient commitment. Some argue that the absence of a comprehensive scheme to modify or revoke a court order, if an individual fails to comply with coerced care, precludes labeling it as an involuntary community treatment provision.¹³² Thus, even from a purely procedural perspective, outpatient commitment is a vague proposal lacking in common definitional elements, to say nothing of a coherent purpose.

Arguably, outpatient commitment is not a radical reform of current practice. A mechanism for providing compulsory community care in a range of settings is already available in most jurisdictions under existing statutes.¹³³ In addition, virtually every state permits the administrative transfer of judicially committed persons from an institution to a community program.¹³⁴ While these provisions may be procedurally flawed,¹³⁵ they nevertheless serve a somewhat similar purpose to outpatient commitment by requiring forced participation in community treatment in exchange for partial release from commitment to an inpatient facility. The acceptable parameters of existing outpatient and adminis-

131. See *infra* Appendix. See also *infra* text accompanying notes 138-214 for a review of state laws.

132. One view holds that the essence of outpatient commitment is the judicial authority, incorporated in the state's civil commitment statute, to require a person to participate in a noninstitutional, mental health program. See Miller & Fiddleman, *supra* note 17, at 148; Myers, *supra* note 9, at 418-20. A contrary position maintains that this judicial discretion is meaningless without enforcement powers; anything less does not qualify as outpatient commitment. See Keilitz, *supra* note 17, at 9.

133. See *infra* Appendix.

134. Forty states have such provisions. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 205 table 4.3, cols. 7-9. For a discussion of several statutes, see *id.* at 206 and *infra* text accompanying notes 215-19.

135. Significant due process problems are inherent in most states' discharge statutes. These constitutional infirmities affect laws governing transfers between state mental institutions, between mental health and correctional facilities, and even between community settings, at least where such movement is to a more restrictive environment. See S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 204, and *infra* text accompanying notes 215-19.

trative discharge schemes are just recently being defined and refined by the courts.¹³⁶

The current debate focuses not so much on whether involuntary community treatment is ever legally possible, but whether it should become more prominent and accessible in the civil commitment process. The real dispute concerns the desirability of substantially modifying commitment standards and procedures to provide enhanced flexibility and, presumably, an enlarged pathway to coerced care. These broader commitment criteria usually represent a significant extension of the *parens patriae* authority. They encompass nondangerous persons who are determined to need mental health treatment, are at least intermittently compliant with psychiatric services, and are likely to suffer "emotional deterioration" without treatment, but are clearly not so handicapped as to be unable to participate in a treatment program or to care independently for themselves.

There is little question that such a substantive statutory modification, achieved through the umbrella of outpatient commitment, is designed to reverse the judicial and legislative trends of restricting commitment criteria to "imminent danger to self or others." Empirical research also demonstrates that the modification will dramatically affect the numbers of people labeled mentally ill who will be caught in the not so safe net of civil commitment.¹³⁷ Moreover, even where outpatient commitment provisions include no alteration in the criteria for involuntary treatment, there is substantial reason to believe that the increased dispositional alternatives may, if utilized, enlarge that commitment net.

A. State Statutory Provisions for Involuntary Outpatient Commitment

Considerable confusion, even among public officials, exists with respect to the meaning and application of involuntary outpatient commitment. A recent national survey of attorneys general and mental health directors in all fifty states, the District of Columbia, Puerto Rico and the Virgin Islands, demonstrates that there is substantial disagreement over whether outpatient commitment is even authorized in their jurisdic-

136. For a discussion of recent cases interpreting involuntary treatment laws, see *infra* text accompanying notes 220-30.

137. A comprehensive study of the impact of revisions in Washington's civil commitment statute found a compelling correlation between lowering the standard and increasing the number of people confined. Durham & La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395 (1985). There was a 180% increase in admissions at the institution which served all of western Washington State, forcing a virtual cap on bed capacity. *Id.* at 411-12.

tions.¹³⁸ Although forty-two administrators believed that their states sanctioned compulsory community treatment,¹³⁹ in instances where both the mental health directors and attorneys general responded to the survey, only seventy-four percent agreed on whether an outpatient commitment provision existed in their respective states.¹⁴⁰

A careful review of state law reveals the omnipresent role of conditional release and the emergence of judicially-ordered outpatient commitment. In 1984, the National Center on State Courts conducted the most comprehensive analysis, which is summarized below based upon the tables reprinted in the Appendix to this Article.¹⁴¹ It indicates that significant differences exist among those states which explicitly permit outpatient commitment in the areas of: (1) community versus hospitalization standards; (2) prehearing and hearing procedures; (3) disposition, rehearing and release options; (4) compliance monitoring and revocation mechanisms; and (5) the specificity, or lack thereof, of the entire outpatient scheme.¹⁴² It demonstrates that involuntary community treatment is not a uniform concept capable of consistent implementation. On the contrary, with the exception of a few states which have substantially endorsed the outpatient commitment model through the enactment of detailed procedures and revised standards, most jurisdictions thus far have not utilized this comprehensive approach, although more may do so in the future. This historical disinclination is probably attributable to a variety of practical problems and implementation obstacles attendant to involuntarily treating people labeled as mentally ill in community programs. It is questionable whether these systemic barriers can be overcome, even in those states which have fully adopted an outpatient commitment model.

138. Miller, *Commitment to Outpatient Treatment: A National Survey*, 36 HOSP. & COMMUNITY PSYCHIATRY 265 (1985).

139. *Id.* at 265.

140. *Id.* at 265-66.

141. See *infra* Appendix. The tables contain citations and classifications of statutory provisions in effect as of 1983. They disclose basic similarities as well as critical differences among state laws. The charts present only statutory provisions that *expressly* apply to involuntary community treatment or apply to *both* involuntary hospitalization and outpatient commitment. Civil commitment standards that generally pertain to all involuntary persons are not included unless the standards specifically mention outpatient commitment. Table headings are not mutually exclusive and are necessarily general because of differences among the statutes. Finally, sections mandating *only* treatment in the "least restrictive alternative" were not considered as explicit authorization for outpatient commitment.

142. See generally *id.*

1. Statutory authorization and substantive standards

State statutes can be classified in one of three major categories: (1) those which do not explicitly authorize outpatient commitment and are therefore thought to preclude it, at least by implication (twenty states);¹⁴³ (2) those which permit compulsory community care but identify no implementation procedures (twelve states and the District of Columbia);¹⁴⁴ and (3) those which both authorize involuntary community treatment and articulate specific implementation provisions (eighteen states).¹⁴⁵ No statute expressly precludes coerced treatment in the community.

The first category can be divided into two classes: (1) those states which equate involuntary civil commitment with inpatient hospitalization and do not even have community program references (nine states);¹⁴⁶ and (2) those which authorize institutionalization only after a

143. See ALA. CODE § 22-52-10 (Supp. 1984); CAL. WELF. & INST. CODE § 5152 (West 1984); CONN. GEN. STAT. ANN. § 17-178(c) (West Supp. 1986); FLA. STAT. ANN. § 394.467(2)(a) (West 1986); IDAHO CODE § 66-329 (I)-(K)(3) (Supp. 1984); IND. CODE ANN. § 16-14-9.1-20 (Burns Supp. 1986); KY. REV. STAT. ANN. §§ 202A.026, 202A.051 (Baldwin Supp. 1982); LA. REV. STAT. ANN. § 28:55(E) (West Supp. 1985); ME. REV. STAT. ANN. tit. 34-B, § 3864(E) (Supp. 1984-85); MD. HEALTH-GEN. CODE ANN. § 10-623 (1982); MASS. GEN. LAWS ANN. ch. 123, § 8 (West Supp. 1984-85); MINN. STAT. ANN. § 253B.09 (West Supp. 1987); MO. ANN. STAT. § 632.335(4) (Vernon Supp. 1987); NEV. REV. STAT. § 433A.310 (1983); N.J. STAT. ANN. §§ 30:4-58 (West 1981); OHIO REV. CODE ANN. § 5122.15(e) (Anderson Supp. 1983); R.I. GEN. LAWS § 40.1-5-8(10) (1984); UTAH CODE ANN. § 64-7-36 (1983); W. VA. CODE § 27-5-4(j) (Supp. 1984); WYO. STAT. § 25-10-110(j) (1982).

144. See ALASKA STAT. §§ 47.30.755 to .760 (Supp. 1984); ARK. STAT. ANN. § 59-1415(c) (Supp. 1985); COLO. REV. STAT. § 27-10-109(4) (Supp. 1986); DEL. CODE ANN. tit. 16, § 5010(2) (1983); D.C. CODE ANN. § 21-545 (1981); MISS. CODE ANN. § 41-21-73(4) (Supp. 1986); MONT. CODE ANN. § 53-21-127(2)(a) (1985); NEB. REV. STAT. § 83-1038 (1981); N.H. REV. STAT. ANN. § 135-B:37 (1977); N.M. STAT. ANN. § 43-1-11(d) (1984); N.Y. MENTAL HYG. LAW § 9.31(c) (McKinney Supp. 1986); PA. STAT. ANN. tit. 50, § 7304(f) (Purdon Supp. 1986); VA. CODE ANN. § 31.1-67.3 (1985).

145. See ARIZ. REV. STAT. ANN. § 36-540 (1986); GA. CODE ANN. §§ 88-506.5 to .7 & §§ 88-508 to -512 (Supp. 1986); HAW. REV. STAT. §§ 334-121 to -134 (1985); ILL. REV. STAT. ch. 91 1/2, paras. 3-811 to -813 (Supp. 1984-85); IOWA CODE ANN. §§ 229.11, 229.14 to .16 (West Supp. 1986-87); KAN. STAT. ANN. §§ 59-2918(a)-(e) (Supp. 1986); MICH. COMP. LAWS ANN. §§ 330.1468 to .1477 (West Supp. 1980); N.C. GEN. STAT. §§ 122C-261 to -294 (1986); N.D. CENT. CODE § 25-03.1-21 (Supp. 1983); OKLA. STAT. ANN. tit. 43A, §§ 5-204, 5-401 to -407 (West Supp. 1986); OR. REV. STAT. § 426.130 (1983); S.C. CODE ANN. § 44-17-580 (Law. Co-op. 1985); S.D. CODIFIED LAWS ANN. §§ 27A-9-18 to -29 (1984); TENN. CODE ANN. §§ 33-6-201 (1984 & Supp. 1986); TEX. REV. CIV. STAT. ANN. arts. 5547-50 to -53 (Vernon Supp. 1985); VT. STAT. ANN. tit. 18, §§ 7617 to 7802 (Supp. 1986); WASH. REV. CODE ANN. §§ 71.05.210 to .320 (Supp. 1987); WIS. STAT. ANN. § 51.20 (West Supp. 1986).

146. See CAL. WELF. & INST. CODE § 5152; CONN. GEN. STAT. ANN. § 17-178(c); IDAHO CODE § 66-329(k)(3); IND. CODE ANN. § 16-14-9.1-20; LA. REV. STAT. ANN. § 28:55(E); MD. HEALTH-GEN. CODE ANN. § 10-623; MO. ANN. STAT. § 632.335(4); N.J. STAT. ANN. § 30:4-58; WYO. STAT. § 25-10-110(j).

finding that there is no less restrictive alternative (eleven states).¹⁴⁷ Massachusetts is typical of the second class. There, although civil commitment requires a threshold determination that no alternative to hospitalization exists,¹⁴⁸ the only disposition available to the court is institutionalization or release.¹⁴⁹

It is sometimes difficult to analyze commitment schemes due to the imprecision of statutory language. For instance, although Nevada is included in the first category, its statute arguably allows outpatient commitment in some form. One section provides that when a court determines that an individual meets the standards for civil commitment, it may order involuntary admission to the "most appropriate course of treatment."¹⁵⁰ The statute also requires the exploration of other forms of care in the least restrictive environment, which is in the best interest of the individual, prior to any order for involuntary admission or the renewal of an existing order.¹⁵¹ Nevertheless, a judge apparently has no discretion to order community treatment and is limited to the one statutorily authorized disposition—commitment to a mental health facility.¹⁵²

Other inconsistencies make classification difficult. Although included in the first category, Minnesota and Kentucky sanction coerced community care *prior* to a judicial determination that the individual meets the commitment standards.¹⁵³ The Minnesota statute permits conditional release to family members or interested individuals. Even though the only judicial disposition allowed is discharge or hospitalization, the court must make specific findings that "voluntary" outpatient care and "release before commitment" are not suitable alternatives.¹⁵⁴ After the hearing but before an order has been entered, the court may release the individual to the custody of any person or agency on the condition that the care and treatment of the individual are guaranteed. The court may revoke this conditional discharge, after notice to the individual and a hearing upon its own motion or upon the petition of any other

147. See ALA. CODE § 22-52-10; FLA. STAT. ANN. § 394.467(1)(b); KY. REV. STAT. ANN. §§ 202A.026, 202A.051; ME. REV. STAT. ANN. tit. 34-B, § 3864; MASS. GEN. LAWS ANN. ch. 123 §§ 4, 8; MINN. STAT. ANN. § 253B.09; NEV. REV. STAT. § 433A.310; OHIO REV. CODE ANN. § 5122.15(e); R.I. GEN. LAWS § 40.1-5-8(10); UTAH CODE ANN. § 64-7-36; W. VA. CODE § 27-5-4(j).

148. See *Commonwealth v. Nassar*, 380 Mass. 908, 406 N.E.2d 1286 (1980).

149. See MASS. GEN. LAWS ANN. ch. 123, § 8(e); see also *Northampton State Hosp. v. Moore*, 369 Mass. 957, 336 N.E.2d 856 (1974).

150. NEV. REV. STAT. § 433A.310(1)(b) (1986).

151. *Id.* § 433A.310(3).

152. *Id.* § 433A.310(1)(b).

153. See KY. REV. STAT. ANN. §§ 202A.051, 202A.081; MINN. STAT. ANN. § 253B.09(1).

154. MINN. STAT. ANN. § 253B.09(1).

person; however, it lacks direct control and supervision over the person's activities.¹⁵⁵

The second category of statutes comprises states which explicitly authorize outpatient commitment but fail to identify any implementation procedures.¹⁵⁶ Given the absence of such practical mechanisms, the likelihood that involuntary community treatment will be a meaningful alternative has thus far been insignificant.

There is also a wide divergence of statutory requirements in this group. For example, Colorado¹⁵⁷ and the District of Columbia¹⁵⁸ permit any form of community treatment which a court believes will be in the best interest of the person *or the public*. This approach may be frequently utilized and subject to abuse if the latter factor becomes a predominant consideration. Virginia allows a person who meets the criteria for involuntary treatment, but who is not in need of hospitalization, to be subjected to court-ordered outpatient care or "such other appropriate treatment modalities as may be necessary to meet the needs of the individual."¹⁵⁹ The statute includes no other reference to community options. These vague and open-ended provisions provide little guidance to courts and could well result in a *de facto* expansion of the standard for coerced treatment in the community.

At the other end of the spectrum is Arkansas, which has enacted a statute with distinct criteria for outpatient commitment.¹⁶⁰ It applies the same test which governs institutionalization but also requires clear and convincing evidence that the person: (1) has been involuntarily committed within the previous two years; (2) is suffering from a mental disease or disorder that has been treated successfully by medication; and (3) becomes severely disabled, homicidal or suicidal when not regularly taking medication prescribed for his or her condition.¹⁶¹ This statute, like most in this group, does not allow competent individuals to refuse treatment.¹⁶² Additionally, it creates a questionable distinction between new and long-term clients of the mental health system, precluding the former from being considered for community treatment.¹⁶³

The third category of statutes comprises those states which not only

155. *Id.* § 253B.09(4).

156. *See supra* statutes cited in note 144.

157. COLO. REV. STAT. § 27-10-109(b)(4).

158. D.C. CODE ANN. § 21-545(b).

159. VA. CODE ANN. § 37.1-67.3.

160. ARK. STAT. ANN. § 59-1409.

161. *Id.*

162. *Id.*; *see also infra* Appendix.

163. ARK. STAT. ANN. § 59-1409.

authorize outpatient commitment but establish detailed implementation procedures for its monitoring, modification and revocation.¹⁶⁴ Significant variation exists concerning the specificity of these statutory provisions.

Oregon is representative of those states with few requirements for involuntary community treatment. Its statute does not even reference alternatives to hospitalization.¹⁶⁵ After determining that an individual meets the civil commitment standard, a court can authorize his conditional release to the care and custody of a legal guardian, relative or friend.¹⁶⁶ The court retains the exclusive discretion to determine whether it is in the individual's best interest to return to an inpatient setting, with no requirement for a revocation hearing.¹⁶⁷

On the other end of the continuum are Arizona, Georgia, Hawaii, Kansas, North Carolina and Tennessee, which have comprehensive provisions for outpatient commitment. It is significant that these are the only jurisdictions which have substantially amended their commitment laws in the past three years, lending substantial support to the claim that comprehensive schemes for involuntary community treatment are a national trend. North Carolina often is viewed as the model for this movement, since strikingly similar legislation has been subsequently enacted by other states, including Hawaii and Georgia.¹⁶⁸

Arkansas, Georgia, Hawaii, Kansas, North Carolina and Tennessee have adopted distinct outpatient commitment standards which differ from the criteria governing involuntary hospitalization.¹⁶⁹ In Arizona, the standards are the same.¹⁷⁰ The new criteria in Georgia, Hawaii, North Carolina and Tennessee are the most glaring testaments to the expansiveness of governmental control inherent in this supposed re-

164. *See supra* statutes cited in note 145.

165. OR. REV. STAT. § 426.130.

166. *Id.* § 426.130(2). This disposition occurs at the end of the commitment proceeding and differs from prehearing provisions found in other states like Minnesota, *see supra* note 154, since the court maintains control over the person.

167. OR. REV. STAT. § 426.130.

168. *See Four States Enact New Mental Health Statutes in 1984*, 2 MENTAL HEALTH L. REP. 3 (1985).

Hawaii's new involuntary outpatient commitment law—only the second of the kind in the nation—headlines the list of new mental health legislation enacted by states last year. . . . Similar to the trail blazing North Carolina law passed in 1983, the Hawaii law allows a family court to commit a person to outpatient treatment if certain conditions are met.

Id. at 3; *see also* KAN. STAT. ANN. §§ 59-2918(a)-(e).

169. *See infra* Appendix table one; KAN. STAT. ANN. §§ 59-2918(a)-(e) and 59-2919.

170. *See* ARIZ. REV. STAT. ANN. § 36-540.

form.¹⁷¹ For instance, in North Carolina a person may be involuntarily hospitalized only if the court finds that the individual is mentally ill or mentally retarded and is dangerous to himself or others.¹⁷² Involuntary community treatment, on the other hand, requires simply that "[b]ased on the respondent's treatment history, the respondent is in need of further treatment in order to prevent further disability or deterioration which would predictably result in dangerousness."¹⁷³

Tennessee permits judicially-ordered treatment if the individual's condition, resulting from a mental illness, is "likely to deteriorate rapidly" to the point that the person would pose a "likelihood of serious harm."¹⁷⁴ This formulation expands the scope of persons subject to involuntary community care from the traditional limitation of currently dangerous to the much lower threshold of *probable* psychological regression and *possible* future dangerousness.¹⁷⁵

The most striking example of this trend is Georgia. Its new statute requires a finding that the individual does *not* meet the standard for involuntary commitment to an institution, but given his condition, will need outpatient treatment to avoid "predictably and imminently becoming an inpatient."¹⁷⁶ By shifting the focus away from current or even future dangerousness, the standard invites a dramatic increase in the number of persons potentially subject to coerced psychiatric care, particularly given the large population of people who are labeled as seriously mentally ill and are always at risk of hospitalization.¹⁷⁷

The other prerequisites for outpatient commitment vary widely among the states. However, almost all mandate a determination that: (1) the person is able to live safely in the community; (2) he is unlikely to become dangerous to himself or others; (3) there is an available commu-

171. See GA. CODE ANN. §§ 88-506.2 and 88-508.2; HAW. REV. STAT. § 334-121; N.C. GEN. STAT. §§ 122-58.2 to -58.11A; TENN. CODE ANN. § 33-6-201.

172. N.C. GEN. STAT. § 122C-263(d)(2).

173. N.C. GEN. STAT. § 122C-263(d)(1).

174. TENN. CODE ANN. § 33-6-104(a).

175. Skeptics who doubt the ability to predict any form of future behavior abound. The problem becomes more complex as the projected actions become more remote. As one commentator succinctly noted:

Standards such as "dangerous" or "need for hospitalization" have no generally agreed upon meaning among lay persons or professionals. Of course, there is likely to be a great deal of agreement about extreme cases, but such cases are unusual. Thus, it may be claimed, each witness, lay or professional, along with each fact finder, injects his or her own private meaning into the criteria, rendering the system essentially lawless.

Morse, *supra* note 12, at 72.

176. GA. CODE ANN. § 88-501 (12.1)(A).

177. Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, 34 HOSP. & COMMUNITY PSYCHIATRY 129, 131 (1983).

nity program; (4) the court has approved a detailed treatment plan; and (5) the person will cooperate with the treatment plan.¹⁷⁸ Michigan is the only state to have a statute which inquires into the individual's preferences concerning alternatives to hospitalization. The effect of these uniform elements of involuntary community treatment ironically may be to narrow the class of individuals who are actually eligible for outpatient commitment, despite broader statutory standards. In fact, by restricting the option to nondangerous, compliant persons, the entire scheme may be available mainly to persons who would otherwise be voluntary recipients of care.

The North Carolina statute obliges the court to make findings of fact that outpatient treatment is available and appropriate.¹⁷⁹ This may be an attempt both to compel availability and to increase communication between local judges and mental health treatment providers. However, problems with implementation continue in North Carolina and elsewhere, raising further questions about the viability of involuntary treatment.¹⁸⁰ The relative dearth of community mental health services in conjunction with increased, but nonetheless ineffective, administrative coordination and monitoring pose substantial obstacles to the widespread use of coerced community care.¹⁸¹ It may be that outpatient commitment already has or will become synonymous with forced medication, given the lack of community mental health alternatives. Curiously, only seven states explicitly authorize psychotropic medication as a form of community treatment,¹⁸² although it is not precluded in the other jurisdictions in this category. In only eight states may an individual be committed to a treatment regimen that does not include a structured, mental health program, such as the custody of family or friends.¹⁸³

Most outpatient commitment statutes do not address the issue of an individual's legal competency and corresponding ability to consent to treatment.¹⁸⁴ Since courts have repeatedly held that commitment, in and

178. See *infra* Appendix table one.

179. N.C. GEN. STAT. § 122C-271(4).

180. See Miller & Fiddleman, *supra* note 17, at 149.

181. Keilitz, *supra* note 17, at 13.

182. ARK. STAT. ANN. § 59-14-09(c); GA. CODE ANN. §§ 88-501 (12.2), 88-501 (17); HAW. REV. STAT. § 334-122; NEB. REV. STAT. § 83-1038; N.C. GEN. STAT. § 122C-3(27); TENN. CODE ANN. § 33-6-201(2); WIS. STAT. ANN. § 51.20(13)(dm); see also *infra* Appendix table one.

183. HAW. REV. STAT. § 334-121(2); MISS. CODE ANN. § 41-21-73(4); MONT. CODE ANN. § 53-21-127(2)(a) (ii)-(iv); N.Y. MENTAL HYG. LAW § 9.31(c); N.C. GEN. STAT. § 122C-263(d)(1)(b); OR. REV. STAT. § 426.130(2); PA. STAT. ANN. tit. 50, § 7304(f); VT. STAT. ANN. tit. 18, § 7617(d).

184. See *infra* Appendix table one.

of itself, does not render a person incompetent nor constitute a determination that he is unable to consent to care,¹⁸⁵ compulsory treatment should not follow ineluctably from a judicial declaration of commitment. Several states, however, have included provisions in their outpatient statutes which require a finding that the person is mentally ill and unable to voluntarily seek or comply with outpatient treatment.¹⁸⁶ This determination partially ameliorates the statutory deficiencies which exist in other jurisdictions. But these additional elements fail to establish any criteria for assessing such "inability" and incorrectly equate it with the legal incapacity to consent.¹⁸⁷ Moreover, to the extent that any serious mental illness is assumed to distort a person's perception of his need for psychiatric intervention, resistance to treatment could be used to prove the predicate of mental disability. Such a tautology solves little and further complicates the delicate task of ensuring meaningful consent.

2. Procedural safeguards and implementation mechanisms

Statutory implementation provisions are even more inconsistent than are their substantive standards. Although all jurisdictions in the third category have prehearing examination procedures, few other states do. Absent from most statutory schemes are requirements to review community alternatives prior to a hearing.¹⁸⁸ For instance, even though Florida specifies a number of options which can be implemented before the initial court appearance, it is unclear whether any resultant community treatment is voluntary or involuntary.¹⁸⁹ This omission is less consequential in those states which mandate probable cause determinations; but it is seriously problematic in others, such as Georgia, whose newly amended statute allows up to thirty days, excluding weekends and holidays, to convene a hearing following the filing of an outpatient petition.¹⁹⁰ It is odd that an individual can be hospitalized involuntarily pending judicial review, after it has already been determined by a mental health professional that he is an appropriate candidate for community care.

Both North Carolina¹⁹¹ and Hawaii¹⁹² permit prehearing confine-

185. *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *Rogers v. Commissioner of the Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983).

186. GA. CODE ANN. § 88-501 (12.1)(B); HAW. REV. STAT. § 334-121(5); N.C. GEN. STAT. § 122C-263(d)(1)(d).

187. See generally *id.*

188. See *infra* Appendix table two, col. 1.

189. FLA. STAT. ANN. § 394.463(2)(c).

190. GA. CODE ANN. § 88-510(a).

191. N.C. GEN. STAT. § 122C-267(a).

ment for up to ten days. There is a presumption in Hawaii that the evaluation will be conducted in the community, but the statute also authorizes commitment to a psychiatric facility when the person will not voluntarily consent to an outpatient examination.¹⁹³ The court has similar discretion in Arizona to order either inpatient or community assessments.¹⁹⁴

Arizona, Hawaii, Kentucky, North Carolina and Wisconsin have provisions for the revocation of prehearing outpatient status.¹⁹⁵ The North Carolina statute further stipulates that if an individual becomes dangerous to self or others and requires hospitalization, the outpatient proceedings are terminated and institutional commitment is automatically initiated.¹⁹⁶

Although only Georgia, Hawaii, Kansas, North Carolina and Tennessee have enacted comprehensive outpatient commitment procedures,¹⁹⁷ several states have ancillary requirements that must be met before involuntary community treatment can be ordered. The most common is a provision permitting courts to admit into evidence, and requiring them to consider, the psychiatrist's written recommendations or testimonial statement, usually rendered by affidavit, regarding the appropriateness of compulsory care.¹⁹⁸

If a court-ordered treatment regimen is violated, the individual is usually subject to involuntary hospitalization for the remainder of the commitment order.¹⁹⁹ Generally, the time periods for coerced community care and institutionalization are the same. Longer periods for outpatient commitment exist in Arkansas,²⁰⁰ Hawaii²⁰¹ and Michigan,²⁰² where the maximum initial period for hospitalization is 45, 90 and 60 days as compared to outpatient orders of 180, 180 and 90 days, respectively. Georgia's initial inpatient confinement is for 180 days;²⁰³ there is no time limit on community care. In Iowa, institutionalization and involuntary community treatment are both authorized for indefinite

192. HAW. REV. STAT. § 334-124.

193. *Id.* § 334-126(g).

194. ARIZ. REV. STAT. ANN. § 36-529(a).

195. *See infra* Appendix table two, col. 1.

196. N.C. GEN. STAT. § 122C-265(e).

197. *See infra* Appendix table two, col. 3; KAN. STAT. ANN. §§ 59-2918(a)-(e).

198. *See infra* Appendix table two, col. 3.

199. *See id.* table four, col. 4.

200. *Compare* ARK. STAT. ANN. § 59-1409 with § 59-1415(c).

201. *Compare* HAW. REV. STAT. § 334-60.5(i) with § 334-127(b).

202. *Compare* MICH. COMP. LAWS § 330.1472(1) with § 330.1472(2)-(3) (West Supp. 1986-87).

203. *See* GA. CODE ANN. § 88-506.2.

periods.²⁰⁴

An individual committed to outpatient treatment is able to petition the court for early termination of the order only in North Carolina, Arizona, Hawaii and Vermont.²⁰⁵ In all of these states there must be prior notice to the court which entered the initial order or within whose jurisdiction the community treatment program is located.²⁰⁶ Hawaii also insists that notice be given to interested parties who are identified in the original order.²⁰⁷ Should any person object to the proposed early discharge, a hearing must be held before a local court.²⁰⁸

Although seventeen jurisdictions have some monitoring and revocation components, only eleven are procedurally distinct from their voluntary treatment sections.²⁰⁹ These eleven states do allow the court to modify the original treatment plan, including ordering involuntary hospitalization, without again considering the person's mental status.²¹⁰ They generally require a hearing to ascertain the cause of noncompliance and to consider appropriate revisions, if any, to the original order.

Revocation and modification of outpatient commitment, including institutional confinement, can occur in six states without a hearing.²¹¹ Such decisions are presumably based on the evidence presented at the original proceeding, the individual's medical record, additional affidavits, and informal recommendations of physicians or other professionals involved in the treatment plan.²¹² The period of hospitalization runs from the date of the initial order. This lack of supplementary procedural protection may reflect the reality that institutional and outpatient commitment result in similar restrictions on liberty and therefore do not implicate separate constitutional interests or involve a significant difference in the conditions of confinement.

Georgia, Hawaii, North Carolina, South Carolina and Vermont do require a full supplemental hearing before a modification or revocation

204. See IOWA CODE ANN. § 229.14(2)-(3).

205. See *infra* Appendix table three, col. 3.

206. *Id.*

207. HAW. REV. STAT. § 334-131.

208. *Id.* § 334-132.

209. See *infra* Appendix table four, cols. 2, 3; KAN. STAT. ANN. § 59-2918(f).

210. *Id.*

211. See *id.*; see also ARIZ. REV. STAT. ANN. § 36-540.D.4 (1986); ILL. ANN. STAT. ch. 91 1/2, para. 3-812(b)(Smith-Hurd Supp. 1987); KAN. STAT. ANN. § 59-2918(f); N.D. CENT. CODE § 25.03.1-21; OR. REV. STAT. § 426.130(2); WASH. REV. CODE § 71.05.320(1); WIS. STAT. § 51.20(13)(d).

212. See ARIZ. REV. STAT. ANN. § 36-540.D.4.

can occur.²¹³ Notice and other procedures equivalent to those in the first proceeding are assured.²¹⁴ The mandate in Hawaii and North Carolina that the commitment process be initiated *de novo* is reasonable, given the different criteria for outpatient and inpatient commitment. However, this justification apparently was not persuasive to the Georgia and Tennessee legislatures when they enacted their new involuntary community treatment statutes and incorporated dual commitment criteria.

B. Conditional Release

Every jurisdiction makes some provision, through statute or regulation, for transfer from an institutional to a community setting even though the person remains under a civil commitment order.²¹⁵ Although the nature and duration of the transfer, the procedures for initiating and revoking the discharge, and the role of counsel, courts and the client in the process may differ among the states, they share the common consequence of sanctioning involuntary participation in community treatment.

These existing release mechanisms do differ in several respects from the purer versions of outpatient commitment. The former is exclusively an administrative option while the latter is primarily a judicial process.²¹⁶ Conditional discharge occurs after a person has been committed to an institution, while involuntary community treatment is a dispositional alternative to hospitalization in the first instance. Few written requirements exist regulating the granting or revocation of conditional release, while several statutes establish detailed criteria and procedures for reviewing and modifying outpatient commitment. Most importantly, the former implies no revision in the commitment standards, while the latter may, but does not necessarily, depend on a lower threshold for depriving individuals of their freedom.

The procedural distinctions between conditional release and outpa-

213. GA. CODE ANN. § 88-506.3(a)-(b); HAW. REV. STAT. § 334-129(c); N.C. GEN. STAT. § 122C-274(c)(1)&(2); S.C. CODE ANN. § 44-17-580(2); VT. STAT. ANN. tit.18, § 7618(b).

214. *Id.* See *infra* Appendix table four.

215. The concept of conditional release is referred to by different names: administrative placement, conditional discharge, parole, leave or visit status. Similar to an administrative transfer, it involves movement of an individual from one sector of the mental health system to another. It differs in that the person technically remains a client of the initial program, regardless of his actual residence. With a transfer, all legal, clinical and administrative responsibility shifts from the originating facility to the receiving one.

216. Most state commitment statutes establish a judicial mechanism for determining whether the standards for confinement are satisfied. A few, like the District of Columbia, vest this authority in a quasi-judicial or formal administrative tribunal. All mandate the traditional indices of due process: notice, hearing, counsel, presence (with exceptions), confrontation, decision and appeal. See S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 122 table 2.7.

tient commitment, however, may be illusory. Both require a formal finding, usually by a court, that the person satisfies the criteria for civil commitment before his liberty can be initially curtailed. While the method for determining where the coerced treatment should be undertaken does differ between the two schemes,²¹⁷ the elaborate process for reviewing, modifying and revoking outpatient orders may apply with equal force to substantial alterations in discharge decisions. This is certainly true when a mental health administrator seeks to reverse the conditional release determination and return the person to an institution.

Courts have recently and repeatedly drawn an analogy between conditional release from an inpatient program and parole from a correctional facility. Since the interests at stake are similar, these cases have concluded that the process for restricting those interests should be parallel, if not identical.²¹⁸ The constitutional minimum necessary to ensure fairness and reliability must be available before a civilly committed person who has been conditionally discharged to a local program can be reinstitutionalized, or perhaps even transferred to another, more restrictive community setting.²¹⁹ Thus, the informality and potential arbitrariness

217. Under most transfer procedures, once institutional confinement is authorized, shifting the locus of the involuntary care is an informal, often unreviewable decision of hospital staff or administrators. It is customarily grounded in unspoken clinical criteria and is often accomplished in unannounced treatment team meetings of which the person is neither informed nor permitted to attend. Outpatient commitment provisions, on the other hand, generally rest on the authority to identify appropriate treatment modalities and localities in a judicial officer, exercised as part of the commitment process.

218. The Supreme Court has applied rigorous procedural protections to the deprivation of liberty occasioned by the revocation of parole, *Morrissey v. Brewer*, 408 U.S. 471 (1972) and probation, *Gagnon v. Scarpelli*, 411 U.S. 778 (1973). That the liberty interests were already restricted was not a determinative factor to the Court. *Morrissey*, 408 U.S. at 481-84. Adopting this reasoning, lower courts have held that the interest of mental health clients in their freedom from institutional confinement, even if conditioned upon compliance with a certain treatment regimen and still remaining subject to a civil commitment order, deserves the same protection. *Birl v. Wallis*, 619 F. Supp. 481 (M.D. Ala. 1985); *Lewis v. Donahue*, 437 F. Supp. 112 (W.D. Okla. 1977); *Meisel v. Kremens*, 405 F. Supp. 1253 (E.D. Pa. 1975); *In re James*, 507 A.2d 155 (D.C. 1986); *Richardson v. Ellerbee*, 481 A.2d 473 (D.C. 1984); *In re True*, 103 Idaho 151, 645 P.2d 891 (Idaho 1982); *In re Cross*, 99 Wash. 2d 373, 662 P.2d 828 (1983). See Note, *Constitutional Law: The Summary Revocation of an Involuntary Mental Patient's Convalescent Leave—Is It Unconstitutional?*, 33 OKLA. L. REV. 366 (1980).

219. Most courts have required notice and some form of hearing, although they differ on whether a judicial or a formal administrative proceeding is sufficient. There is less consensus on the issue of whether legal counsel is necessary, particularly after the Supreme Court's decision in *Vitek v. Jones*, 445 U.S. 480 (1980), where only a plurality supported the person's right to be represented by an attorney at a transfer hearing. *Id.* at 496-97. A few courts have rejected the parole analogy and entrusted the revocation decision entirely to clinicians. See *Hooks v. Jaquith*, 318 So.2d 860 (Miss. 1975); *Dietrich v. Brooks*, 27 Or. App. 821, 558 P.2d 357 (1976). But the better and more modern view that due process requirements apply to parole revocations was convincingly expressed by the court in *Birl*:

ness of conditional release may no longer be constitutionally acceptable. Instead, clinical decisions to substantially modify involuntary community treatment must be subject to similar procedural requirements, whether accomplished pursuant to administrative discharge or outpatient commitment provisions.

C. *Judicial Interpretations of the Outpatient Statutes*

The concept of outpatient commitment, and particularly its analogue, conditional release, may not be new, but the frequent use of these options apparently is. Few courts have been asked to interpret involuntary community treatment provisions or even to apply them to specific facts.²²⁰ Only two cases have been found which directly address the constitutionality of outpatient commitment; both were limited to challenges against dissimilar community and inpatient procedures.²²¹ The few published decisions reflect a cautious acceptance of the approach, a narrow reading of the standards and a reluctance to sanction unbridled clinical discretion in modifying mandated treatment.²²² Not surprisingly, there

Parole and the trial visit program share several characteristics. First, both constitute a conditional release intended to permit the parolee or patient to demonstrate that he can function in society. "The parolee has been released from prison based on an evaluation that he shows reasonable promise of being able to return to society and function as a responsible, self-reliant person." Similarly, the trial visit is a "test of . . . ability to cope," according to Bryce Hospital's manual. Furthermore, both the parolee and the mental patient on trial visit enjoy considerable liberty. "Subject to the conditions of his parole, [the parolee] can be gainfully employed and is free to be with family and friends and to form the other enduring attachments of normal life." Birl was equally free from restraints on trial visit, for the evidence showed that Birl was required only to "try to situate [himself] back into the community" and to continue with therapy and medication. In light of the similarities between parole and trial visits, the Court's conclusions in *Morrissey* clearly apply. Regardless of the fact that Birl's release on trial visit was only conditional, therefore, he was still entitled to certain procedural protections before his release could be terminated. As the Court noted in *Morrissey*, "the liberty is valuable and must be seen as within the protections of the Fourteenth Amendment. Its termination calls for some orderly process[.] [sic]"

619 F. Supp at 490 (citations omitted) (quoting *Morrissey v. Brewer*, 408 U.S. 471, 482-83 (1972)).

220. The dearth of reported decisions may be misleading. Many states have only recently enacted comprehensive legislation authorizing outpatient commitment and have not had much opportunity for reviewing these laws. Moreover, commitment matters are customarily decided by lower courts which usually do not report their decisions, making analysis of actual practice difficult. Except in a few jurisdictions like the District of Columbia, Illinois, Minnesota and Washington, these cases apparently are rarely appealed.

221. *In re G.K.*, 147 Vt. 174, 514 A.2d 1031 (1986) (indeterminate order for involuntary community treatment violated due process); *Wisconsin ex rel. Watts v. Combined Community Servs. Bd.*, 122 Wis. 2d 65, 362 N.W.2d 104 (1985) (lack of periodic review of involuntary community placement denies equal protection).

222. *See Birl v. Wallis*, 633 F. Supp. 707 (M.D. Ala. 1986); *In re James*, 507 A.2d 155 (D.C. 1986); *In re Cross*, 99 Wash. 2d 373, 662 P.2d 828 (1983).

is a principled concern with process and a generous deference to the doctrine of the least restrictive alternative.

Most courts have been preoccupied with procedural protections. This is especially evident in the frequent situation where a person contests the attempt by a mental health professional to impose more restrictive treatment conditions—usually hospitalization. If convinced that the statute incorporates sufficient safeguards to minimize error, judges have often been willing to overlook substantive deficiencies or to ignore constitutional challenges.²²³ What constitutes adequate process is itself in dispute, with a few courts receptive to an argument for flexibility and unreviewed authority advanced by clinicians.²²⁴ The majority, however, have maintained a rather rigid adherence to adversarial models and require the full panoply of due process rights.²²⁵

223. See *In re McPherson*, 176 Cal. App. 3d 332, 222 Cal. Rptr. 416 (1985); *In re Mills*, 467 A.2d 974 (D.C. 1983).

224. *Mills*, 467 A.2d at 974. The court reasoned that since an individual "enjoyed only very limited freedom . . . he was required to participate in any treatment regimen prescribed by the hospital staff . . ." *Id.* at 976.

Another panel of the District of Columbia Court of Appeals determined that summary hospitalization of a person who had a full hearing prior to the initial outpatient commitment order is constitutionally permissible, provided that the superintendent files an affidavit with the court within 24 hours of the person's confinement describing the treatment noncompliance and resultant deterioration. *In re Richardson*, 481 A.2d 473, 481 (D.C. 1984). The court assumed that "the probable value of a judicial hearing is not great . . . [since] [t]he decision to return the patient will be made by mental health professionals familiar with his medical history." *Id.* at 483. The court was convinced that the government's interest in confining a person who fails to adhere to a treatment plan and its efforts to "restore the individual to sanity" would be "thwarted" by an adversarial hearing, where "speedy intervention is frequently necessary to prevent rapid deterioration" and "to preserve the advances made toward rehabilitation." *Id.*

225. *C.R. v. Adams*, 649 F.2d 625 (8th Cir. 1981) (court abstained, but strongly suggested detailed procedures are appropriate). In *In re G.K.*, the Vermont court declared that since involuntary community care impinges on the rights of travel and freedom from unwarranted intrusion on bodily integrity, heightened procedural protections are necessary. It found the protections due to be no less rigorous than those governing involuntary institutionalization. *G.K.*, 514 A.2d at 1032. This approach is in marked contrast with the relaxed standard adopted in the District of Columbia. See *Richardson*, 481 A.2d 473 (court can include provision in outpatient order permitting reevaluation and temporary placement in an inpatient facility without the need for additional hearing or judicial review). Ironically, the *Richardson* court based its conclusion on a similar understanding of the implications of involuntary treatment. "The outpatient will be compelled to participate in a prescribed course of treatment and must abide by severe restraints governing his freedom of movement. Similarly, as he lives in a 'controlled experiment with freedom,' his actions will be scrutinized and evaluated by psychiatrists, family and the court." *Id.* at 482. But the District of Columbia Court of Appeals disagreed with the Vermont Supreme Court in its assessment of the relevant factors to be considered and the proper balance to be struck in safeguarding those interests:

Further, any interest the outpatient has in not being labeled mentally ill is greatly attenuated here since he has been adjudicated as mentally ill and dangerous and institutionalized on numerous occasions in the past. . . . Moreover, the outpatient's

There is less consensus concerning the proper standard for revocation of outpatient status. In part, the divergence results from distinct provisions of state law which are often vague and varied.²²⁶ One view holds that noncompliance with court-ordered treatment, demonstrated by competent evidence, is sufficient in and of itself to justify rehospitalization.²²⁷ In other jurisdictions, there must be a determination that the person currently satisfies the criteria for institutionalization before he can be transferred to an inpatient setting.²²⁸ Within the latter group, there is considerable disagreement as to whether a *de novo* hearing on the person's current mental state and present dangerousness is necessary, or whether prior findings on these issues can be relied upon to effectively renew or revise the commitment order.

Finally, in almost every state there is at least token recognition of the doctrine of the least restrictive alternative. Hospitalization is rarely ordered without some mention that it is the most appropriate environment which, under the circumstances of the case, is also the least intrusive upon the person's liberty.²²⁹ But what constitutes such a substantial intrusion and what evidence of other community programs must be considered varies widely among the states.²³⁰ However, a common theme

interest in these cases is only in the continued enjoyment of his conditional release pending the outcome of certain medical and factual determinations due him.

Id. This view may have been repudiated by a more recent decision of the District of Columbia's Court of Appeals. See *James*, 507 A.2d at 155.

226. See *supra* text accompanying notes 138-214 and *infra* Appendix.

227. *McPherson*, 176 Cal. App. 3d 332, 339-40, 222 Cal. Rptr. 416, 419-20; *Richardson*, 481 A.2d 473, 479-80; *Cross*, 99 Wash. 2d 373, 662 P.2d 828.

228. *Birl*, 633 F. Supp. at 711 (court "rejects the notion that hospital should be free to reconfine a newly released patient at the first sign of trouble so as to prevent . . . further deterioration"); *In re Crouse*, 65 N.C. App. 696, 698-99, 309 S.E.2d 568, 570 (1983) (inpatient commitment findings were sufficient to sustain outpatient order); *In re Crainshaw*, 54 N.C. App. 429, 283 S.E.2d 553 (1981) (commitment reversed because standard was not satisfied); *In re G.S.*, 118 Wis. 2d 803, 348 N.W.2d 181 (1984) (although appeal dismissed as improperly presented, court notes that whether community status can be revoked absent new finding of dangerousness raises serious constitutional issue).

In the only reported direct challenge to the standard for temporary hospitalization, the Wisconsin Supreme Court invalidated a portion of its outpatient commitment statute, holding that the state's power to institutionalize a person who is subject to involuntary community treatment must be founded on a determination that the individual is or will be dangerous to himself or others. *Combined Community Servs. Bd.*, 122 Wis. 2d at 89, 362 N.W.2d at 115-16.

229. *James*, 507 A.2d 155; *In re W.H.*, 144 Vt. 595, 481 A.2d 22 (1984).

230. *In re Lufsky*, 379 N.W.2d 255 (Minn. Ct. App. 1986) (hospital is least restrictive alternative when person resists community care); *In re M.C.*, 716 P.2d 203 (Mont. 1986) (hospital is least restrictive alternative); *In re J.B.*, 705 P.2d 598 (Mont. 1985) (failure to take medication requires institutionalization and precludes further consideration of community services); *In re Cuypers*, 389 N.W.2d 812 (N.D. 1986) (noncompliance with outpatient treatment regimen renders institutionalization necessary).

does emerge throughout the cases: implementing outpatient commitment procedures is a far more complex task than legislating them.

V. THE IMPLEMENTATION MAZE

While outpatient commitment has been an available option in most jurisdictions for many years, several factors have precluded states from relying extensively on what is arguably a more desirable alternative. These operational barriers include: (1) the lack of appropriate community mental health programs; (2) the difficulty of compelling committed individuals to comply with treatment plans; (3) the probability that few persons would comply with court-ordered treatment and yet be unwilling to voluntarily participate in a community program; (4) the reluctance of mental health providers to treat their clients involuntarily and subject themselves to judicial supervision; (5) the absence of judicial mechanisms and personnel to adequately supervise outpatient care; (6) the resistance of neighbors and public officials to accept committed persons in their community; (7) the fears of professionals concerning liability for inadequate treatment or foreseeable harm; and (8) the potential creation of a governmental obligation to fund a comprehensive system of community services for individuals subject to outpatient commitment.

Even those few jurisdictions that have substantially modified their statutes to incorporate detailed provisions for outpatient commitment have had little success in achieving the promised benefits of this model.²³¹ On the contrary, while more people are being confined to institutions under revised commitment criteria,²³² few are being placed in

231. With a few exceptions, most states which have had some form of involuntary community care have never evaluated its impact. The most scientific and controlled research design just published assesses several hundred clients committed under a new Tennessee post-hospital commitment law. It concluded: "At the very least, we can say that the data do not support the effectiveness of the law." Bursten, *supra* note 17, at 1257. An earlier empirical study in North Carolina came to the same conclusion: "[The statutory] changes did not make a significant difference in the effectiveness of outpatient commitment as a therapeutic modality." Miller & Fiddleman, *supra* note 17, at 149. A review of practices in Arizona, Arkansas and Hawaii by the National Institute of Mental Health concurred. Owens, *supra* note 17, at 23, 28, 36; *see also* LRA REPORT, *supra* note 11.

232. A careful analysis of the consequences of lowering the commitment standard in the state of Washington revealed striking evidence of increased utilization and decreased quality of care. Durham & La Fond, *supra* note 137, at 434-35. The authors warned:

This study provides strong empirical evidence that revising statutory commitment criteria to expand the state's authority to confine and treat mentally ill persons for therapeutic purposes will significantly increase the number of individuals involuntarily committed to psychiatric facilities. . . . Without adequate additional resources, other mentally ill persons, most of whom are probably indigent, who had previously sought and received inpatient care and treatment from the public mental health system on a voluntary basis, will be unable to obtain these services and will be left to

community settings, even under compulsion of a court order. The practical problems of providing psychiatric care in the community have not been adequately addressed by these statutory reforms. Given their magnitude and complexity, they probably cannot.

A. *The Availability of Community Services*

Rarely are commentaries on mental health law or policy published today which do not include some scathing criticism about the depopulation of public mental hospitals over the past twenty years and the failure of most states to develop adequate community support services.²³³ These observations range from the insightful to the irrational. Some recognize that the much heralded social policy of community mental health care was, and still is, a viable systemic reform that has not failed but just has never been meaningfully attempted.²³⁴ Other critics ignore the lure of real estate tax incentives and the consequences of supply side economic theory when they insist that the homelessness crisis in America's cities is primarily the product of deinstitutionalization.²³⁵ Regardless of the reli-

fend for themselves as best they can. Enacting a civil commitment statute that expands the power of the state to commit mentally ill persons for therapeutic purposes also raises the strong possibility that a large number of persons will become institutionally dependent for the first time in their lives. Many of these patients may well become chronic users of state psychiatric hospitals. . . .

This study also warns that, if a state legislature is determined to expand dramatically the reach of the involuntary civil commitment system, it must at the same time appropriate adequate additional resources if it is to have any hope of achieving the therapeutic purposes sought. Failure to provide sufficient funding for such a legislative initiative could result in overcrowded state mental health institutions with potentially harmful consequences to patients.

Id. at 444; see also Durham, *Implications of Need-for-Treatment Laws: A Study of Washington State's Involuntary Treatment Act*, 36 HOSP. & COMMUNITY PSYCHIATRY 975 (1985).

233. E. TORREY & S. WOLFE, CARE OF THE SERIOUSLY MENTALLY ILL (Public Citizen Health Research Group 1986); Bassuk & Gerson, *Deinstitutionalization and Mental Health Services*, 238 SCI. AM. 46 (1978); DeRisi & Vega, *The Impact of Deinstitutionalization in California's State Hospital Population*, 34 HOSP. & COMMUNITY PSYCHIATRY 140 (1983); Talbott, *The Fate of the Public Psychiatric System*, 36 HOSP. & COMMUNITY PSYCHIATRY 46 (1985). See also S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 31 n.74 and *Commitment in North Carolina*, *supra* note 29, at 992 n.28 for articles discussing this issue.

234. *Deinstitutionalization of the Mentally Ill: Hearings Before the Subcomm. on Fiscal Affairs and Health of the House Comm. on the District of Columbia*, 97th Cong., 1st Sess. 155 (1981) (statement of John A. Talbott, Professor of Psychiatry, Cornell University Medical College); Pepper & Ryglewicz, *Testimony for the Neglected: The Mentally Ill in the Post-Deinstitutionalized Age*, 52 AM. J. ORTHOPSYCHIATRY 388, 389 (1982). In perhaps the most illuminating article, Dr. Rohn Friedman identifies the social and clinical determinants of this country's inertia in honoring its community commitment to people with serious mental disabilities. Friedman, *Resistance to Alternatives to Hospitalization*, 8 PSYCHIATRIC CLINICS OF N. AM. 471, 472-78 (1985).

235. The clinical interpretation of the nation's homelessness dilemma as the product of misguided community mental health policies ignores the stark reality that it is first and foremost a

ability of the research or the soundness of the theory, all agree that, with the exception of a few geographic areas, comprehensive community care is a myth. There is an unusual degree of consensus among parties who rarely share common views that the first priority for almost all states should be the development of an adequate array of less restrictive community alternatives.²³⁶ More than any tinkering with involuntary treatment criteria or wholesale modifications of civil commitment schemes, the actual availability of community programs would have the most dramatic impact on the current crisis in mental health care.

Ironically, outpatient commitment advocates invoke this historical failure and present dilemma as a justification for compelling treatment in the community. They argue that an attractive and effective means to stem the "revolving door" syndrome produced by irresponsible deinstitutionalization is to enhance the government's and psychiatrist's authority to coerce care. Statutory modifications, if not the sole solution, are certainly the primary one.

In the absence of a meaningful alternative, however, outpatient commitment is no more than a theoretical possibility. To achieve the allegedly beneficent purposes of the model, a comprehensive system of community services is necessary so that appropriate treatment can be provided according to the unique needs of each individual. A few additional programs will not do. A collective of alternatives which are adequately staffed and monitored must be available if modifications in the person's treatment plan are required. These must encompass a spectrum of residential program models ranging from relatively independent hous-

housing problem. Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899 (1984). The shortage of affordable low-income and transient rental units is more directly attributable to real estate tax shelters, condominium conversion in urban centers and massive reductions in federal housing benefits than the consequence of any institutional mental health program.

236. COMMITMENT GUIDELINES, *supra* note 11, at 423-24, 512. Some states have already tried to develop alternatives to involuntary civil commitment. See, e.g., LRA REPORT, *supra* note 11, at 226-33 (Virginia), 280-82 (New York), 333-35 (Arizona, California, Missouri and Wisconsin); Keilitz, *supra* note 112, at 732. See generally Hammaker, *A Client Outcome Evaluation of the Statewide Implementation of Community Support*, 7 PSYCHOSOCIAL REHABILITATION J. 2 (1983); McGraw & Keilitz, *The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment*, 6 WHITTIER L. REV. 35 (1984); Miller & Fiddleman, *supra* note 17, at 148; Owens, *supra* note 17, at 23 (Arizona), 30 (Arkansas), 37 (Hawaii), 53; Stein & Test, *supra* note 85.

Data reveals that of the more than seven billion dollars controlled by state mental health agencies, less than 25% is devoted to community and outpatient care. NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, FUNDING SOURCES AND EXPENDITURES OF STATE MENTAL HEALTH AGENCIES: REVENUE/EXPENDITURE STUDY RESULTS FISCAL YEAR: 1983 at 8, 11 (1985). This figure does not include federal Medicaid funding which is exclusively used to support inpatient services in private facilities.

ing to structured and well-staffed community living arrangements. Similarly, an integrated network of nonresidential services must be available, including emergency crisis intervention, respite care, clinical assessment, service coordination and case management, support in daily living skills, employment training, recreation, socialization and medication. Unless a sufficient array of programs is created, there will be no place to commit people. If only a few medication clinics and day treatment centers are established, outpatient commitment will promptly resemble its inpatient counterpart—judicially-mandated placement in settings wholly incapable of providing even minimally adequate or individually appropriate care.

In short, for outpatient commitment to be more than the empty promise of deinstitutionalization, states must first do what they have thus far been unwilling to do: implement their social, statutory and fiscal policies of community mental health care. This is at the least expensive, and at best, unlikely. It is difficult to believe local legislatures will fund the development of a system of treatment, training and support services that has a sufficient capacity to assist individuals unwilling to accept voluntary care when these same elected officials have ignored the pleas of consumers, families, professionals, advocates and judges to establish such programs for truly needy persons who desperately seek help without any coercion.²³⁷ Absent this effort, outpatient commitment is a dysfunctional legal response to a service system vacuum.

B. Compelling Compliance With a Treatment Regimen

It is well established that many people labeled mentally ill are less than enamored with traditional psychiatric interventions and clinical techniques.²³⁸ The literature in this area is replete with descriptions of categories of people prone to reject involvement with a medically-oriented mental health system.²³⁹ Often this resistance is considered symp-

237. E. TORREY & S. WOLFE, *supra* note 233, at 18; see also Talbott, *Toward a Public Policy on the Chronic Mentally Ill Patient*, 50 AM. J. ORTHOPSYCHIATRY 43 (1980). Optimistic projections on the likelihood of community program development resulting from commitment law revisions have been disproved before. See Bleicher, *supra* note 12, at 101.

238. Consumer satisfaction surveys are rare. However, the literature, public policy positions and presentations of the consumer movement strongly reflect dissatisfaction, if not disgust, with traditional mental health programs. J. CHAMBERLAIN, *ON OUR OWN* (1978); J. Chamberlain, *The Case Against Involuntary Treatment* (Oct. 16, 1986) (unpublished manuscript presented to the 1986 Annual Conference of the National Association of Rights Protection and Advocacy, Boston, Massachusetts). One of the more extreme distortions is the psychiatrists' claim that this disenchantment actually reflects a deeper desire to be treated with traditional clinical interventions, but that this preference is subtly masked by the very thought disorder that requires fixing. See Chodoff, *supra* note 17, at 498.

239. A comprehensive study of over 3500 individuals has identified several factors relating

tomatic of a disability, if not a critical characteristic of the illness itself. The "treatment noncompliance" of certain state hospital clients is repeatedly cited as the foremost clinical issue to be addressed by outpatient commitment.²⁴⁰

If those diagnosed as needing treatment were willing to accept these offers of professional cures, civil commitment could be largely abolished. The debate regarding involuntary treatment would become virtually moot, rendering it unnecessary to resolve whether there is in fact a disease at all and whether governmental action is appropriate to promote certain citizens' mental health.²⁴¹ One possibility for achieving this goal is to dramatically improve the attractiveness, accessibility and quality of the services offered. Presumably, by making the offer more enticing, there will be more takers. There would also be the additional clinical advantages associated only with voluntary care that often have been noted by mental health experts.²⁴²

to noncompliance, including race, age, behavior, length of stay in community programs, family involvement, and drug and medical complications. See M. Durham & H. Carr, *Outpatient Commitment: The Use of Less Restrictive Alternatives to Civil Commitment* (1985) (unpublished manuscript); see also Bachrach, *Young Adult Chronic Patients: An Analytical Review of the Literature*, 33 HOSP. & COMMUNITY PSYCHIATRY 189, 192 (1982); Dembo, *The Impact of the Intake Experience on Clients Dropping Out of Treatment at CMHC*, 4 J. PSYCHOLOGY, TREATMENT & EVALUATION 345 (1982); Geller, *Rights, Wrongs, and the Dilemma of Coerced Community Treatment*, 143 AM. J. PSYCHIATRY 1259, 1261 (1986); Miller & Fiddleman, *supra* note 17, at 148; Morse, *supra* note 12, at 85 n.138; Owens, *supra* note 17, at 31; Willis, *The Many Faces of the Hesitant Patient*, 1 PSYCHOTHERAPY PATIENT 37 (1984).

240. Compulsory community treatment is primarily directed to those individuals who are frequently admitted to inpatient facilities and are sadly burdened with yet another label—"revolving door patients." Bursten, *supra* note 17, at 1255; Geller, *supra* note 239, at 1259; Editorial, *supra* note 17, at 1270. In fact, its justification depends heavily on demonstrating that this cycle can be broken or, as one legislative committee put it, to ensure that "their needs for rehospitalization will be reduced to near nothing." Owens, *supra* note 17, at 40 (report of the North Carolina Mental Health Study Commission). Based on all available empirical evidence, the program is a marked failure in alleviating this problem. Bursten, *supra* note 17, at 1257 (no reduction in admissions which could be attributed to law); Miller & Fiddleman, *supra* note 17, at 149 (new law increased rate of rehospitalization).

241. See generally Morse, *supra* note 12; Szasz, *On the Legitimacy of Psychiatric Power*, 14 RUT.-CAM. L.J. 479 (1983).

242. Enhancing the responsiveness of services can only benefit everyone. It may also reduce the need for involuntary confinement, particularly if early intervention efforts are included. McGraw & Keilitz, *supra* note 236, at 48. Morse recognized that quality would increase not only costs but also demand: "I assume that if fine services were freely available in the community, there would be a great demand for such services." Morse, *supra* note 12, at 87 n.144; see also Davis, Egri & Caton, *Outcomes of Care Systems for Chronic Patients*, 76 J. NAT'L MED. A. 67 (1984); Stein & Diamond, *A Program for Difficult to Treat Patients*, in THE TRAINING IN COMMUNITY LIVING MODEL: A DECADE OF EXPERIENCE (Stein & Test ed. 1985).

Providing treatment on a voluntary basis has always been regarded as the preferred approach. O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring). It offers the maximum opportunity for growth and healing, to say nothing of dignity and self-

If this is impossible or impractical, however, then forcing treatment remains a potential technique for providing psychiatric care. Coerced intervention requires enforcement mechanisms and, ideally, compliance incentives. Whereas commitment to an institution is implemented by a system of locked doors, regimented living schedules and the lure of increased freedom incorporated in the "privilege" system, court-ordered outpatient treatment cannot be so easily mandated.²⁴³ Even assuming the public would tolerate the scenario of a disabled person being dragged through the street to his therapy appointment or day program, there is probably no one able and willing to do the dragging. Actually forcing psychiatric treatment is physically difficult, legally questionable and publicly unacceptable.

This obvious obstacle to implementing mandated treatment substantially limits the utility of the model. Only those individuals who are at least somewhat willing to accept mental health care and comply with judicially-approved treatment regimens are deemed eligible for outpatient commitment.²⁴⁴ This precondition of cooperation appears remarkably similar to a test of voluntariness. If the model is primarily, if not

esteem. See LRA REPORT, *supra* note 11, at 351-53; Durham & La Fond, *supra* note 137, at 432 & n.156; Morse, *supra* note 12, at 102, and the references cited *supra* at note 187; *Developments*, *supra* note 7, at 1399 & nn.1, 3-4; Note, *Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and the Role of the Attorney*, 26 U. FLA. L. REV. 508, 524 (1974).

243. There are few effective methods for forcibly imposing the treatment. Locks and physical restraint have a legacy of punishment but are apparently functionally useful in controlling people. To date, no one has suggested their transference to community living arrangements or clinics. The threat of reinstitutionalization is supposedly the principal leverage to promote compliance, but its utility is now in substantial doubt. Bursten, *supra* note 17, at 1257; Miller & Fiddleman, *supra* note 17, at 149. Some recognize that little can be done to actually ensure the treatment but naively suggest that compliance will present little problem. Myers, *supra* note 9, at 432-33. Perhaps the most outrageous incident involved a psychiatrist who simply decided to abrogate the function of the court, circumvent the law, and unilaterally enforce treatment plans. See Geller, *supra* note 239, at 1260, 1262. By disregarding the statutory requirement of imminent dangerousness, the doctor illegally committed, on an involuntary basis, anyone in his care who refused to cooperate with his medication regimen. *Id.* at 1261. For this lawless action, he was commended for his courage in the American Journal of Psychiatry. See Editorial, *supra* note 19, at 1271. Less dramatic statutory subterfuges have been reported by other psychiatrists. See *Commitment in North Carolina*, *supra* note 29, at 1006 n.92.

244. State statutes or policies usually require client cooperation with proposed community treatment as a precondition to outpatient commitment. See ARIZ. REV. STAT. ANN. § 36-540B (Supp. 1984). But see TENN. CODE ANN. § 33-6-201, 205 (Supp. 1984). See also LRA REPORT, *supra* note 11, at 364. Sometimes these same statutes then preclude coerced treatment for individuals who will voluntarily accept it. *In re Farrow*, 41 N.C. App. 680, 255 S.E.2d 777 (1979). If only compliant individuals will be considered for compulsory treatment, but client consent vitiates the legal basis (to say nothing of the practical reason) for the coercion, outpatient commitment might be a viable option for a null class.

exclusively, restricted to those willing to accept mental health care, the tautology is completed and outpatient commitment is rendered obsolete before it begins.

Constitutional barriers to compelling compliance also must be addressed. For potential recipients of outpatient commitment, psychotropic medication is usually a critical component of the prescription for treatment.²⁴⁵ In fact, it is the reluctance of many individuals to diligently adhere to medication schedules that renders them the most promising candidates for involuntary community treatment, since this is the preferred form and most easily implemented method of coerced care. In an increasing number of states, however, the forcible administration of these mind-altering drugs requires a compelling state interest to override the constitutional and/or common-law rights not to be treated except pursuant to informed consent.²⁴⁶ Where the individual is incapable of making a meaningful treatment decision—an essential element of commitment pursuant to the *parens patriae* authority²⁴⁷—judicial approval is

245. Psychiatrists forthrightly acknowledge that the most convincing clinical rationale for involuntary community care is to force resistant patients to take their drugs: "Clinicians argue that outpatient commitment is ideal for a patient who can be maintained in remission with medication but who does not take it voluntarily or consistently. They contend that continued court supervision is justified by the patient's history of repeated psychotic episodes when medication is discontinued." Miller & Fiddleman, *supra* note 17, at 149. Not surprisingly, the data which is reported in the medical literature supports the efficacy of judicial orders to follow the doctor's advice. See *id.* at 150; see also Geller, *supra* note 239; Hilday & Goodman, *The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness*, 10 J. PSYCHIATRY & L. 81 (1983).

246. The right to refuse psychiatric treatment, as a separate legal entitlement, is of recent origin and has a questionable future. It was conceived in unique circumstances which blended fundamental first amendment values with the effects of mind-altering interventions. See *Winters v. Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971); *In re Boyd*, 403 A.2d 744 (D.C. 1979); *Kaimowitz v. Department of Mental Health*, No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), *reprinted in* 1 MENTAL DISABILITY L. REP. 147, 151-53 (1976). As the principle emerged into the arena of traditional state hospital practices, it met a less favored reception. *Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (1983).

Fortunately for the right and its intended beneficiaries, it was recast into the familiar doctrine of consent. See Schwartz, *Equal Protection in Medication Decisions: Informed Consent, Not Just the Right to Refuse*, in *THE RIGHT TO REFUSE MEDICATION* 74 (1986). There it thrived. See *Rogers v. Commissioner of the Department of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983); *In re Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *In re K.K.B.*, 609 P.2d 747 (Okla. 1980).

247. See Hermann, *supra* note 19, at 102; La Fond, *supra* note 22, at 527; Myers, *supra* note 9, at 431. As New York's highest court recently stated: "For the state to invoke [its *parens patriae*] interest, 'the individual himself must be incapable of making a competent decision concerning treatment on his own. Otherwise the very justification for the state's purported exercise of its *parens patriae* power—its citizen's inability to care for himself . . . would be

necessary.

Arguably, outpatient commitment procedures could incorporate this legal requirement of incompetency and the necessary judicial review, but almost no statutes do so. As a practical matter, few clinicians or policy makers would endorse such significant limitations on the model. Its proponents candidly admit that coerced community care is designed to "abrogate[] the right[s] of competent people to refuse treatment."²⁴⁸ Its effectiveness depends on being able to compel those who resist psychiatric interventions—usually psychotropic medication—to follow a prescribed regimen of care; the individual's *capacity* to appreciate the options is irrelevant. Thus, the issue is not competency but rather preference: when a person chooses not to take the drugs which a psychiatrist deems necessary, and some form of psychological deterioration is predicted to follow, coercion is considered desirable.²⁴⁹

Even if outpatient commitment was limited to individuals incapable of rendering a meaningful treatment decision, in many jurisdictions the administration of involuntary psychotropic medication can only be sanctioned upon a showing that the person's substituted judgment would be to accept the treatment.²⁵⁰ For those individuals who have repeatedly refused to take medication as prescribed—the primary subjects of the involuntary community treatment proposal—it is doubtful that their substituted judgment would be to consent to the drugs.²⁵¹ Thus, unless out-

missing." *Rivers*, 67 N.Y.2d at 496, 495 N.E.2d at 343, 504 N.Y.S.2d at 80 (quoting *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980)).

248. Bursten, *supra* note 17, at 1256. See Geller, *supra* note 239; Editorial, *supra* note 19.

249. Miller & Fiddleman, *supra* note 17, at 149; see also Geller, *supra* note 239, at 1260, 1262. It is here that even the legal advocates of outpatient commitment part company with their clinical counterparts. The law professors insist that a finding of decisionmaking incapacity is a threshold precondition for coerced treatment when it is undertaken for the individual's own benefit. See *supra* note 247. In fact, even the leading psychiatric commentators on civil commitment support this incompetency criteria for state intervention. See A. STONE, *supra* note 72; Roth, *supra* note 72. It would appear that the preference of some clinicians for coercion, regardless of capacity, represents an extreme view, even in the psychiatric community. See Geller, *supra* note 239, at 1261.

250. *In re Boyd*, 403 A.2d 744, 750-52 (D.C. 1980); *Rogers*, 390 Mass. at 498, 458 N.E.2d at 314-15.

251. A critical factor, if not the prime determinant, of substituted judgment analysis is the person's expressed preference. Since the principle is designed to illuminate whether an incompetent individual would consent to a proposed treatment, were he capable of making an informed decision, any indications of prior assent or refusal to accept care—certainly if rendered at a time when the person was competent, and even if not—are the best evidence of future decisions. For individuals who repeatedly refuse to continue taking antipsychotic medication, there is strong support for the legal assumption that their substituted judgment would be *not* to consent to these drugs. This assumption is compelling if the prior refusal was a competent decision, made while on medication and supposedly benefiting therefrom. Thus forced drug-

patient commitment statutes are held to invalidate this emerging line of cases and the legal basis on which they are founded, the primary goal of coerced community care is probably constitutionally impermissible.

C. *The Few People Left to Commit*

It is quite possible that only those persons labelled as mentally ill who are: (1) appropriate for care in *existing*, available mental health programs; (2) not presently dangerous; (3) not otherwise diverted from the involuntary mental health system; (4) compliant with prescribed treatment; and (5) judicially determined to have consented to proposed medication under a substituted judgment analysis will be eligible for outpatient commitment. The obvious question is who is left. Is this group sufficiently large to generate all this legal debate? Would the enactment of comprehensive outpatient provisions really benefit many people? It is doubtful.

Others have recognized the reality that the practical and legal constraints on involuntary community treatment substantially restrict the class of persons eligible for this beneficent coercion.²⁵² They have also noted that, in light of the small number of potential subjects, existing statutory mechanisms can accomplish the same objectives.²⁵³ It is only by ignoring these obstacles, as some naively do,²⁵⁴ or by proposing a dramatic enlargement of commitment criteria, as all proponents inevitably must, that outpatient commitment has any real meaning. The proposal is thus reduced to its true purpose: to expand the circle of involuntary

ging through judicial compulsion may be the most problematic for those individuals who have documented histories of noncompliance with treatment regimens.

252. The Institute on Mental Disability and the Law of the National Center for State Courts has observed:

Only a minority of patients—the most severely ill and those most likely to be dangerous—penetrate the involuntary civil commitment system to the point of a judicial hearing Even if involuntary outpatient commitment is properly and conscientiously used, it may have limited application because it is, by definition, a part of the involuntary civil commitment laws and practices and must conform, at least theoretically, to those laws and practices.

Keillitz, *supra* note 17, at 38; *see also* COMMITMENT GUIDELINES, *supra* note 11, at 497; Burs-ten, *supra* note 17, at 1258; Keillitz, *supra* note 112, at 732-33; Owens, *supra* note 17, at 24, 64.

Whatever the precise percentage, it is clear that the number of persons subject to outpatient commitment roughly decreases as the availability and quality of voluntary community services increases. This is obviously true of responsive prescreening programs, which can divert the majority of those in need of some support or assistance from any form of involuntary treatment. *See* COMMITMENT GUIDELINES, *supra* note 11, at 427-28; LRA REPORT, *supra* note 11, at 338-44.

253. Conditional release can effectively serve the same ends. *See* COMMITMENT GUIDELINES, *supra* note 11, at 510-11; *see also supra* text accompanying notes 215-19.

254. Myers, *supra* note 9, at 432; Editorial, *supra* note 17.

commitment, not to shift the locus of compulsory care.²⁵⁵ As such, it must confront the constitutional challenges to expansive applications of the *parens patriae* authority which have prevailed over the past two decades.²⁵⁶ Even more significantly, it must also contrive a mechanism for ensuring that people with mental disabilities attend programs which usually do not exist in neighborhoods that will not permit them to develop.

D. *The Resistance of Community Mental Health Agencies*

Compelling care in community settings depends on the cooperation and active endorsement of those local agencies which provide the treatment. Service delivery models differ amongst states, ranging from publicly-operated and funded community hospitals or clinics to systems comprised entirely of private nonprofit providers supported in part by governmental contracts. This latter model has been the principal approach encouraged by the federal government for the past two decades, beginning with the Community Mental Health Centers Construction Act in 1963.²⁵⁷ Yet there is substantial evidence that these programs have not been responsive to individuals considered to be seriously mentally ill.²⁵⁸

The ability to control admissions to and discharges from community mental health agencies has frequently been noted as a critical problem in relying on private mental health agencies as alternatives to state-operated institutions. The freedom to reject potential clients is a treasured option for most providers which goes to the very core of their stature as an independent professional corporation. For many, there is neither an organizational mission nor interest in serving individuals with severe disa-

255. See Appelbaum, *Is the Need for Treatment Constitutionally Acceptable as a Basis for Civil Commitment?*, 12 LAW, MED. & HEALTH CARE 144 (1984); Bleicher, *supra* note 12, at 113-14; Chodoff, *supra* note 17; Geller, *supra* note 239, at 1262-63; Hermann, *supra* note 9, at 100; *Commitment in North Carolina*, *supra* note 29, at 1021-22; Myers, *supra* note 9, at 427.

A number of states have heeded this call and established a lower standard for involuntary community treatment than that which governs inpatient commitment. See *supra* note 20 and *infra* Appendix; see also Keilitz, *supra* note 112, at 720; McGraw & Keilitz, *supra* note 236, at 61. The research shows these legislative modifications have not been honored nor have they been successful. See *supra* note 231.

256. See cases cited *supra* note 30.

257. The Act was originally enacted as Pub. L. No. 88-164, 77 Stat. 282 (1963). It was recently repealed by the Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, § 902(e)(2)(B), 95 Stat. 357, 560 (1981).

258. The failure of the community mental health centers (CMHCs) to fulfill their statutory mandate is chronicled in E. TORREY & S. WOLFE, *supra* note 233, at 12-14; see also Goldman, Regier & Taube, *Community Mental Health Centers and the Treatment of Severe Mental Disorder*, 137 AM. J. PSYCHIATRY 83 (1980); Miller, *The Community Psychiatrist as Public Defender*, 16 PSYCHIATRIC OPINION 34 (1979).

bilities—precisely those persons who are traditionally cared for in public mental hospitals and subject to involuntary commitment.²⁵⁹ Even more problematical, the very service delivery principles which underlie community mental health care are simply inconsistent with forcibly medicating individuals labeled as mentally ill or compelling their attendance in local treatment programs.²⁶⁰

Nevertheless, community mental health agencies play the pivotal role in implementing most outpatient commitment schemes. Since the individual is judicially entrusted to their care, providers must be aware of, and at least reluctantly assent to, individual commitment petitions.²⁶¹ Significant monitoring and enforcement responsibilities are imposed on these agencies, which they attempt to fulfill through case management and outreach programs, although occasionally they resort to physical or mechanical means.²⁶² If noncompliance problems arise, the program must initiate revocation, modification, or other remedial processes, and

259. Bursten, *supra* note 17, at 1258; Miller & Fiddleman, *supra* note 17, at 150 & n.13. In their North Carolina study, Miller and Fiddleman determined that the data supported a sweeping conclusion:

A more significant problem lies in the reluctance of CMHC staff to treat unwilling patients. As indicated by their questionnaire responses and by the authors' previous study, their attitudes ranged from total rejection of working with committed patients to strong skepticism concerning the value of outpatient commitment. The severely and chronically mentally ill, who have the most to gain from outpatient commitment, are also the most expensive to treat in terms of staff time; outreach efforts and frequently missed appointments are costly. Many community mental health clinics continue to view state hospitals as the preferred treatment locus for such patients rather than accepting the responsibility of providing community based treatment.

Id. (footnote omitted).

260. The basic philosophy of the community mental health movement has always been grounded in principles of client choice, social integration, and clinical professionalism. LRA REPORT, *supra* note 11, at 365. Whether these goals have been realized is another matter. See E. TORREY & S. WOLFE, *supra* note 233, at 12. The nonmedical orientation of many community mental health workers has increased the resistance to authoritarian approaches and forced drugging. Miller & Fiddleman, *supra* note 17, at 150.

261. A significant statutory reform enacted as part of North Carolina's attempt to improve the effectiveness of its outpatient commitment law included the requirement that the community facility had to participate in the decision to seek involuntary treatment and had to agree it was the most effective method before a court could order compulsory care. See N.C. GEN. STAT. § 122C-273(a)(2) (Supp. 1985); see also *Commitment in North Carolina*, *supra* note 29, at 997 n.61. Other states also attempt to mandate the cooperation of local agencies. LRA REPORT, *supra* note 11, at 321 (Arizona); Bursten, *supra* note 17, at 1258 (Tennessee). It is usually of little consequence given the resistance of these agencies to treat committed persons. See Miller & Fiddleman, *supra* note 17, at 150.

262. The few studies concerning outpatient commitment which do exist identify its primary function as a means to coerce medication. Miller & Fiddleman, *supra* note 17, at 150. But presumably it can be applied to compel a person to live in a community residence or to attend a day program. If treatment compliance is an issue and escape from the facility is a possibility, the program might seek to lock its doors or employ restraint. California effectively accom-

prove the relevant facts at judicial or administrative hearings. Where the agency lacks the capacity to monitor or the will to enforce the commitment order, involuntary outpatient treatment becomes a seldom-invoked option.

It is quite possible that creative contracting and new program agendas could modify some of the longstanding resistance of many mental health providers to serving the most needy citizens.²⁶³ But to require local agencies to submit to ongoing judicial supervision and to enthusiastically participate in commitment proceedings is asking too much. Even if they could put aside their value-based opposition to compulsory care, it is unrealistic to expect local providers to willingly assume a host of new and complex responsibilities. There are simply no incentives, despite a myriad of disincentives, for local agencies to seek court orders for treating their clients; to dedicate scarce professional resources to testifying in court; to be responsible for the ongoing supervision of committed persons; and to report regularly to judges on their clients' progress or lack thereof.²⁶⁴ Not surprisingly, associations of community mental health agencies are often among the most vocal opponents of outpatient commitment legislation.²⁶⁵ Without their support, the model is of questiona-

plishes this through its conservatorship commitment of incompetent individuals to locked nursing facilities. McGraw & Keilitz, *supra* note 236, at 57-58.

263. Some state mental health agencies require their vendors to agree to a zero-reject system and accept all referrals made by district or area mental health offices. Western Massachusetts exemplifies this approach. See *infra* text accompanying notes 298-324. Other states such as Pennsylvania have successfully experimented with performance contracting mechanisms, with premiums awarded for serving more difficult clients. By transferring control to the states of all federal mental health block grant funds distributed under the Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, 95 Stat. 357 (1981), Congress offered the states a powerful tool to reverse the history of a private provider-controlled system.

264. This understandable reluctance has been identified as a critical obstacle to the meaningful utilization of outpatient commitment. See Bursten, *supra* note 17, at 1258; Miller & Fiddleman, *supra* note 17, at 150; Owens, *supra* note 17, at 17, 30. Even its psychiatric proponents lament the time and resources wasted in endless judicial proceedings. Appelbaum, *The Rising Tide of Patients' Rights Advocacy*, 37 HOSP. & COMMUNITY PSYCHIATRY 9, 10 (1986); Editorial, *supra* note 19.

While the establishment of community programs which are entirely state-operated as well as publicly-funded might possibly reduce the likelihood of agency resistance to serving certain clients, it does not address the costs associated with the ongoing supervision of treatment decisions. In order for outpatient commitment to function effectively, this supervision must be extensive. A national task force of clinical and legal experts recommended that outpatient treatment plans, comprised of at least seven basic elements, must be initially approved by the court. A hearing must be held at which all relevant professionals and mental health workers could be subpoenaed to testify, if a party challenges any portion of the plan. COMMITMENT GUIDELINES, *supra* note 11, at 508.

265. Miller & Fiddleman, *supra* note 17, at 150. "During the task force hearings on the proposed changes in the North Carolina statutes, the major objections came from CMHC

ble utility.

E. The Expanded Judicial Role

Even with the reluctant endorsement of community mental health programs and their clients, outpatient commitment mandates a new role for the courts. The courts must demonstrate the will to release people with mental disabilities from institutions and develop a working familiarity with the range of dispositional alternatives. Further, they must exercise the constitutionally questionable authority to order and monitor the provision of involuntary treatment on an individual basis. Finally, the courts must discover additional resources to achieve these goals, including a capacity to ensure compliance with their orders through personnel similar to probation officers.

The first of these roles is risky at best. In jurisdictions where a version of outpatient commitment is available, studies have demonstrated that judges are either unfamiliar with the option or unwilling to exercise it.²⁶⁶ While the lack of adequate programs may partially explain this disinclination, the proliferation of community agencies which would result from the creation of a comprehensive system would make knowledge of dispositional alternatives even less likely.²⁶⁷ Except for a few unusually interested and courageous judges, there is little reason for courts to experiment with involuntary community treatment, at least where institutional confinement is a viable option.

directors who did not want to be forced to treat committed patients." *Id.* See COMMITMENT GUIDELINES, *supra* note 11, at 496.

266. COMMITMENT GUIDELINES, *supra* note 11, at 499; see also Hoffman & Foust, *supra* note 113, at 1138 (judges unlikely to commit to community program, even when apparently appropriate, unless all clinicians agree that institutionalization is unnecessary); McGraw & Keilitz, *supra* note 236, at 63; *Commitment in North Carolina*, *supra* note 29, at 1011 n.14.

267. It is not uncommon for a community mental health system to include a multitude of models operated by dozens of agencies at geographically dispersed sites. This diversity is frequently cited as the system's greatest strength, since it permits far greater flexibility to respond to individual client's needs than the institutional approach. But for judges who have been schooled in inpatient commitment and who justifiably require some showing of the quality of care and security provided by any alternative, this continuum is confusing at best. See COMMITMENT GUIDELINES, *supra* note 11, at 499; Chambers, *supra* note 83, at 1168-77; Hoffman & Foust, *supra* note 113, at 1137-38. If that judicial confidence must be developed by an understanding of and familiarity with the various programmatic options and treatment interventions which might be included in a commitment order, the educational challenge may be prohibitive. In the absence of such an effort, there is likely to be disuse or abuse of the process. See COMMITMENT GUIDELINES, *supra* note 11, at 499.

There is also the simple truth that judges are not especially inclined to take risks, particularly with individuals who appear disoriented, regardless of how much information is available about certain alternatives. See Chambers, *supra* note 83, at 1123 & 1188-89; Hoffman & Foust, *supra* note 113, at 1126.

Judicial involvement in individual treatment decisions is even more troubling. The Supreme Court has repeatedly admonished judges not to intrude into the domain of clinical judgment nor to substitute their views for those of qualified professionals.²⁶⁸ Unless courts are to routinely defer to the recommendations of petitioning psychiatrists, outpatient commitment proceedings will require judges to assess the merits of each component of the proposed treatment plan. Unlike traditional inpatient commitment which involves only two alternatives—confinement or release—involuntary community care is heralded as a multi-faceted, flexible device that permits the crafting of an individualized treatment order including one or several sites, modalities and prescriptions. Moreover, this process must be repeated periodically, and may well occur even more frequently if the individual's needs change or if compliance with a treatment regimen becomes an issue.²⁶⁹

Given this possibility of extensive entanglement in individual treatment decisions by the courts, it seems probable that they will simply adopt the recommendations of the state's experts, making outpatient commitment primarily a vehicle for enforcing the judgments of professional caretakers. But even ardent advocates of outpatient commitment differ widely with respect to the role of judges in formulating and enforcing the details of the individual treatment order. Although the legal commentators recognize the institutional limitations of the judiciary, they would generally have courts be fully informed of the details of community treatment, stopping just shy of reviewing medication dosages.²⁷⁰ The clinical proponents argue for minimal court oversight, decrying external review of their authority and applauding defiant, self-initiated ac-

268. *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Parham v. J.R.*, 442 U.S. 584, 607 (1979).

269. The appeal of outpatient commitment is arguably its individualization. Rather than judicial commitment orders merely identifying the place of confinement, they would, instead, incorporate entire treatment plans. The plans, and presumably the orders, would be modified periodically, according to the developing facts in each case. *Myers*, *supra* note 9, at 421-22; *see COMMITMENT GUIDELINES*, *supra* note 11, at 508-10, 512-13.

270. *See COMMITMENT GUIDELINES*, *supra* note 11, at 508. The commentary on the guidelines notes:

Without an opportunity for review and the possibility of challenge, preparation of a treatment plan can easily become a meaningless ritual and an additional onerous task to be performed by overtaxed clinicians, rather than an effective technique for ensuring that respondents are provided appropriate services. Accordingly, paragraph (d) urges that the parties be entitled to present evidence supporting or questioning treatment plans and that the court, if requested, accept the responsibility for approving, modifying, or ordering revision of the plan.

Id. at 509.

tion.²⁷¹ If consensus on this critical issue touches such sensitive, parochial concerns, then consistent application or implementation is illusory.

There is little doubt that absent some meaningful compliance-monitoring mechanism, the promise of outpatient commitment as a flexible dispositional option will remain largely unfulfilled. Evidence of the current practice in many jurisdictions supports this prediction.²⁷² Community agency staff are obviously the primary mechanism for monitoring compliance with the court's order. But given the resistance of these agencies and the necessity for the court to ensure the integrity of its own process, some form of independent judicial supervision is necessary.²⁷³ One alternative would be the appointment of judicial personnel analagous to probation officers who would be responsible for identifying compliance issues and regularly reporting to the court.²⁷⁴ The establishment of a new branch of the judicial bureaucracy solely for people labeled mentally ill is not likely to engender wide public support. Nor is the concept of mental health police especially captivating. It is doubtful that state legislatures would be eager to fund such a system. Yet the absence of the necessary resources and personnel to oversee outpatient commitment orders invites disregard and ultimately disrespect for the model.

F. Community Acceptance of Committed Persons

Little data and much speculation exists regarding local community receptivity to involuntarily committed persons moving next door.²⁷⁵ Of

271. See Editorial, *supra* note 19, at 1271 ("We are faced with the prospect of lawyers overseeing and intervening in patients' day-to-day care.").

272. McGraw & Keilitz, *supra* note 236, at 64; see also Bursten, *supra* note 17; Owens, *supra* note 17, at 24, 46.

273. There is unanimity among all concerned that, in the absence of effective compliance-monitoring, modification and revocation mechanisms, "involuntary outpatient commitment is undistinguishable from outright release and the hope that a respondent would seek outpatient treatment voluntarily." COMMITMENT GUIDELINES, *supra* note 11, at 513 n.8; see also *Commitment in North Carolina*, *supra* note 29, at 996.

There is less agreement about the form this enforcement process should take. The usual recommendation relies on judicial monitoring. COMMITMENT GUIDELINES, *supra* note 11, at 513; Myers, *supra* note 9, at 426. A more radical proposal relies on self-initiated and unreviewable psychiatric coercion, which in some circles is considered "courageous." Editorial, *supra* note 17, at 127.

274. See COMMITMENT GUIDELINES, *supra* note 11, at 512-14; Chambers, *supra* note 83, at 1176-77.

275. Few articles or research studies note any widespread enthusiasm or even reluctant acceptance for welcoming people labelled as mentally ill next door. COMMITMENT GUIDELINES, *supra* note 11, at 499; *Commitment in North Carolina*, *supra* note 29, at 1019 n.137. The political reality of confronting neighborhood hostility when new programs attempt to

course, many of these individuals may already be there, at least in states like Hawaii and North Carolina which have lowered the standard for outpatient commitment. Under many of these outpatient commitment schemes, people labeled mentally ill who could not otherwise be institutionalized and who reside in a variety of private and public settings would be placed under the supervision of a court and be required to follow a prescribed treatment regimen. It is possible that neighbors and public officials would even support compulsory psychiatric care, particularly for disabled persons who were provocative, annoying, or simply unseemly.

Even with an enlargement of commitment criteria, however, involuntary community treatment might also result in the commitment to local programs of some individuals who would otherwise be confined in public institutions. This would not remain a secret for long. When citizens realize that this statutory revision—even if promoted in reaction to prior libertarian reforms—authorizes the discharge to community programs of mentally ill persons once considered in need of hospitalization, public opposition is likely.²⁷⁶

More enlightened attitudes may prevail temporarily, but they are certain to evaporate after the first committed person fails to comply with his treatment plan and causes some major disturbance or physical harm. Increased awareness of the difficulty of compelling compliance with mandated treatment programs would only aggravate the reaction.²⁷⁷ While people labeled mentally ill may not be any more dangerous as a group than the general population, there is no recent evidence suggesting that they are decidedly less so.²⁷⁸ Even the most effective prescreening, combined with a statutory standard limiting the outpatient option to nondangerous persons, will not and cannot foreclose the possibility of an inflammatory incident. Such an incident is as certain as the public outcry, although it is unclear which will come first.

purchase residential sites is far more poignant and painful than opinion questionnaires disclose.

276. Neighbors will certainly protest since even the families of committed individuals complain about the release of their own relatives. *Commitment in North Carolina*, *supra* note 29, at 1006 n.93. The public association of craziness and dangerousness is pronounced. *Id.* at 1018 n.133.

277. The practical obstacles would soon become public knowledge. *See supra* text accompanying notes 238-51.

278. *See* La Fond, *supra* note 22, at 510-11 nn.55-59; *Commitment in North Carolina*, *supra* note 29, at 1020 n.138.

G. The Risk of Liability

Mental health agencies may resist providing involuntary community treatment primarily for their self-interest, but they are also especially sensitive to the real risks of liability. Courts have been increasingly willing to award damages against mental health professionals when their actions are at least partially responsible for or causally related to serious harm.²⁷⁹ New duties have been formulated in some states.²⁸⁰ The courts have also enunciated more liberal constructions of causation and foreseeability.²⁸¹ Other areas of medical liability may also have influenced this surge in psychiatric litigation.²⁸²

Disabled persons have invoked traditional causes of action to remedy harm sustained from their caretakers. The recent articulation of constitutional entitlements to safety, freedom, and a limited right to treatment for institutionalized persons has resulted in a new wave of mal-

279. The list of possible common law causes of action against psychiatrists is growing steadily. See, e.g., *Dick v. Watonwan County*, 562 F. Supp. 1083 (D. Minn. 1983) (unnecessary hospitalization); *Clites v. Iowa*, 322 N.W.2d 917 (Iowa Ct. App. 1982) (excessive medication); *Davis v. Lhim*, 124 Mich. App. 291, 335 N.W.2d 481 (1983) (negligent release); *Zipkin v. Freeman*, 436 S.W.2d 753 (Mo. 1968) (improper relationship with the patient); *Clark v. State*, 99 A.D.2d 616, 472 N.Y.S.2d 170 (App. Div. 1984) (failure to hospitalize); *Gunnarson v. State*, 95 A.D.2d 797, 463 N.Y.S.2d 853 (App. Div. 1983) (failure to protect the patient); *Bell v. New York City Health & Hosps. Corp.*, 90 A.D.2d 270, 456 N.Y.S.2d 787 (App. Div. 1982) (inadequate evaluation).

280. Most common law claims of negligence are based upon the traditional standard of due care, although the content of this general duty has evolved for the psychiatric profession. For instance, the duty to warn third parties of potential harm is a substantial expansion of psychiatrists' responsibility and liability. The doctrinal development began with *Tarasoff v. Regents of the Univ. of Calif.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). It was soon adopted in other jurisdictions. *Department of Health & Rehabilitative Servs. v. McDougall*, 359 So. 2d 528 (Fla. Dist. Ct. App. 1978); *Bradley Center v. Wessner*, 250 Ga. 199, 296 S.E.2d 693 (1982); *Davis v. Lhim*, 124 Mich. App. 291, 335 N.W.2d 481 (1983); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500 (App. Div. 1979); *Petersen v. State*, 100 Wash. 2d 421, 671 P.2d 230 (1983). For a discussion of the scope of this still-emerging claim, see S. BRAKEL, J. PARRY & B. WEINER, *supra* note 3, at 582-89.

281. Suicide is an important area where courts are increasingly inclined to impose liability by finding that the risk was foreseeable and therefore the harm could have been averted. *Smith v. United States*, 437 F. Supp. 1004 (E.D. Pa. 1977). Predicting the danger that will result from the discharge of a hospital resident is another area where courts are willing to impose liability. *Durflinger v. Artiles*, 234 Kan. 484, 673 P.2d 86 (1983). Expanding the duty to warn beyond identifiable victims to encompass the public at large is perhaps the most startling and significant dilution of the requirement that the danger be foreseeable. *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980); *Petersen*, 100 Wash. 2d 421, 671 P.2d 230.

282. The receipt of substantial damage awards for permanent injuries associated with improper medication and torts such as wrongful birth have generated increased knowledge and interest among lawyers in the negligent care provided to people with handicaps. See *Clites*, 322 N.W.2d 917 (\$800,000 damage award for excessive drugging which resulted in tardive dyskinesia).

practice suits.²⁸³ This is especially true in decisions to discharge or place on visit status handicapped individuals who subsequently harm others.²⁸⁴ Even the constitutionally-based preference for placement in a less restrictive alternative has not always shielded psychiatrists from liability for releasing or transferring an institutional resident to a community program.

Conversely, longstanding doctrines of sovereign immunity and governmental policy exceptions to liability have been waived through tort claims procedures and civil rights statutes.²⁸⁵ Although the former are often narrowly drawn and the latter, at least in the federal courts, are being radically recast to exclude many negligent acts, damage claims proliferate. Whatever remains of legal limitations on financial risk is generally applicable only to state agencies and employees. This limited liability rarely extends to private mental health providers, even if they are performing a governmental function.²⁸⁶

283. *Youngberg v. Romeo*, 457 U.S. 307, 317-18 (1982); *Sabo v. O'Bannon*, 586 F. Supp. 1132, 1139-41 (E.D. Pa. 1984); *Gann v. Delaware State Hosp.*, 543 F. Supp. 268, 273-74 (D. Del. 1982).

284. *Pangburn v. Saad*, 73 N.C. App. 336, 326 S.E.2d 365 (1985); *Durflinger*, 234 Kan. 484, 673 P.2d 86. Courts usually recognize a strong public policy in promoting the community reintegration of people labeled as mentally ill and recognize a potential conflict caused by the imposition of liability when a release decision is subsequently determined to be unwise. Nevertheless, they often elect to naively assume the conflict will evaporate in light of the generous impulses of all concerned:

This presupposes, however, that a psychiatrist will put his own interests above those of his patient. Perhaps the cynical believe that a psychiatrist will refuse to discharge his patient for fear of incurring liability even though the doctor recognizes that under medical standards his patient should be released. We refuse to adopt such a view. Regardless of their potential liability, we believe that psychiatrists will comply in good faith with the standards of their profession. We cannot agree with defendant that imposing liability on psychiatrists, under limited conditions, for their patients' acts will interfere with achieving society's goal of reducing unnecessary hospitalization of the mentally ill.

Davis, 124 Mich. App. at 302, 335 N.W.2d at 488.

285. Most states have enacted procedures mirroring the Federal Torts Claim Act, 28 U.S.C. § 2671 (1982), which abrogate their sovereign immunity and establish a mechanism for compensating victims for the negligent acts of state employees. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 258 (West 1984 & Supp. 1986); N.C. GEN. STAT. § 143-291 (Supp. 1983). These statutes usually do not extend to intentionally inflicted injuries or to malicious, bad faith, or grossly negligent actions of state workers.

The immunity which is granted to public officials for constitutional wrongs is not absolute. *O'Connor v. Donaldson*, 422 U.S. 563, 576-77 (1975). In fact, since the constitutional rights to safety, treatment, freedom from harm and from unnecessary restraint are now clearly established, even qualified immunity may not be available. *Sabo v. O'Bannon*, 586 F. Supp. 1132, 1141 (E.D. Pa. 1984).

286. Whether private physicians are considered state actors for purposes of the fourteenth amendment is unclear. This question is usually resolved by examining the factual nexus between the doctor and state agency, the existence of any public duty to provide treatment through private parties, the common law basis for the doctors' acts, and the existence of state

A few outpatient commitment statutes contain express provisions granting immunity to mental health workers for providing involuntary treatment.²⁸⁷ Most do not. In those states that have limited grants of immunity, the protection extends only to actions authorized by court order or taken in good faith pursuant to the statutory scheme; it does not insulate grossly negligent, intentional or unconstitutional acts.²⁸⁸ But even if the scope of these liability actions is restricted, the risk of litigation or large damage awards will not be lessened. And the current trend in state law is not to shift the burden of the occasional but predictable injury from mental health professionals to the victims through immunity provisions.

Community clinicians already burdened with escalating malpractice insurance premiums are not enthusiastic over assuming responsibility for the involuntary treatment of persons who are not receptive to treatment, whose compliance cannot be easily monitored and whose behavior cannot be readily predicted.²⁸⁹ Their fears of an increasing price tag for involuntary community care are exacerbated by predictable judicial decisions holding community clinics²⁹⁰ and psychiatrists²⁹¹ responsible for

policies or relevant factors which create a special relationship between the government entity and the clinician. *Birl v. Wallis*, 619 F. Supp. 481, 491 (M.D. Ala. 1985) (even though community mental health centers are private, nonprofit organizations, they are sufficiently involved with the provision of public mental health services to be considered state actors); *Willacy v. Lewis*, 598 F. Supp. 346 (D.D.C. 1984) (local doctor's emergency commitment to public mental hospital for *evaluation and examination* is not state action, but compulsory transportation may be); *Lombard v. Eunice Kennedy Shriver Center for Mental Retardation*, 556 F. Supp. 677 (D. Mass. 1983) (state duty to provide medical care to institutionalized residents); *Ruffler v. Phelps Memorial Hosp.*, 453 F. Supp. 1062 (S.D.N.Y. 1978) (where private hospital performs public function with respect to confinement, state action exists).

287. North Carolina is the most prominent example. N.C. GEN. STAT. § 1220-58 (Supp. 1983). See *infra* Appendix.

288. Even in North Carolina, with its apparently absolute immunity provision that governs state hospitals, the courts limited the protection to physicians and excluded grossly negligent conduct. *Pangburn*, 73 N.C. App. at 342-43, 326 S.E.2d at 372. The release of a previously committed individual over his parent's strong objection was enough to constitute gross negligence. The same court noted that the much-heralded outpatient immunity provision affords less insulation from liability, allowing recovery for any departure from professional standards. See *id.* at 347-48, 326 S.E.2d at 372.

289. The medical community is clearly worried. One researcher noted that liability concerns were a major obstacle to the utilization of coerced treatment in three of the five states surveyed, all of which had recently enacted comprehensive outpatient schemes. Owens, *supra* note 17, at 24, 30, 38. The calls for greater flexibility in mandating community treatment are usually joined with demands for relief from liability risks. See Appelbaum, *Civil Rights Litigation and Mental Health: Section 1983*, 32 LAW & PSYCHIATRY 305 (1981); Editorial, *supra* note 19, at 1270.

290. In *Peck v. The Counseling Center of Addison Co.*, 146 Vt. 61, 499 A.2d 422 (1985), the Vermont Supreme Court held that a community mental health agency had a duty to take appropriate steps to prevent potential harm to identified victims from one of its clients who

the consequences of their clients' behavior. Even with limited immunity, outpatient commitment is likely to be expensive, at least to the treaters and their insurance companies.

H. Expanded Entitlement to Community Services

During the past two decades, courts have regularly held that the deprivation of freedom through involuntary commitment required the government to place the person in an environment which least restricted his liberty.²⁹² Impressive arguments have been made that this principle extends beyond the mere consideration of available settings and encompasses the obligation to create alternative programs which equally serve the state's interests in security and treatment.²⁹³ Initially, in the context of structural reform litigation, these rationales were successful and resulted in the wholesale modifications of entire systems of care. Subsequently, the same reasoning was applied to individual commitment cases to force the establishment of noninstitutional alternatives, at least where a professional consensus existed that further hospitalization was harmful or unnecessary.²⁹⁴

The conceptual framework for these developments has always been grounded in involuntary confinement. Although courts have been increasingly sensitive to the reality that the label of commitment is not the only measure of involuntariness, some showing of a deprivation of liberty

was being seen on an outpatient basis. A similar conclusion was reached by an Illinois court of appeals, when a mental health facility failed to control one of its clients whom it knew should be involuntarily committed. *Estate of Johnson v. Village of Libertyville*, 146 Ill. App. 3d 834, 496 N.E.2d 1219 (1986); *see also Johnson v. County of Los Angeles*, 143 Cal. App. 3d 298, 191 Cal. Rptr. 704 (1983).

291. The omnipresent issue of ensuring compliance with prescribed treatment presents even more demanding liability problems. If courts continue to hold physicians responsible for failing to hospitalize persons who subsequently harm an unidentified member of the general public, as they have already done, then no sensible psychiatrist will assume the risk of involuntarily treating community clients, or if they do, will quickly reinstitutionalize them upon even the vaguest indication of some difficulty. *Currie v. United States*, 111 F.R.D. 56 (M.D.N.C. 1986) (failure to hospitalize allegedly dangerous person, even if there is no identifiable victim or specifically known harm, renders psychiatrist liable for resultant injuries); *Clark v. State*, 99 A.D.2d 616, 472 N.Y.S.2d 170 (App. Div. 1984) (failure to respond to warnings from roommate that patient was not taking medication regularly and had missed therapy appointments was sufficient to find doctor liable for failing to rehospitalize individual); *Petersen*, 100 Wash. 2d 421, 671 P.2d 230 (decision not to petition for commitment is not within discretionary act exception to state tort claims act, therefore doctor can be held liable for consequential injuries caused by client in the community).

292. *See* cases cited *supra* note 30.

293. *See* cases cited *supra* note 115.

294. *See Clark v. Cohen*, 794 F.2d 79 (3d Cir.), *cert. denied*, 107 S. Ct. 235 (1986); *Thomas S. v. Morrow*, 781 F.2d 367 (4th Cir.), *cert. denied*, 106 S. Ct. 1992 (1986).

is required.²⁹⁵ Outpatient commitment schemes would extend this preferred classification beyond the institutional walls. Statutory reforms which also include a different (and lower) standard for involuntary community treatment would substantially expand the numbers of people in this class. For all of these individuals, new constitutional rights could be asserted, including, at least, a plausible claim for the appropriate community service consistent with professional judgment.²⁹⁶ States aware of the entitlement implication of outpatient commitment might be hesitant to embark on this path. If public funding for adequate community services is not available prior to the initiation of an outpatient commitment model, it may well be compelled by it. Such an indirect reallocation of resources is likely to be a serious disincentive for legislatures, executive officials and all but the most conspiratorial of policymakers.

Of course, if involuntary community treatment is to have any practical significance, the states must first establish the programs to which people can be committed. Presumably this common sense chronology will reduce the threat of compelling funding for compelled treatment. It might even eliminate the need for all forms of coercion.²⁹⁷ However, since no system of care is ever wholly adequate, there will always be individual cases where an entitlement to a particular type of alternative service, founded on the involuntariness of community care, can be asserted.

VI. THE MASSACHUSETTS MODEL

It is difficult to imagine a jurisdiction where all of these implementation obstacles have been satisfactorily addressed. But in one region of Massachusetts, the most critical have been overcome and several others rendered unnecessary. It is a model not for the successful implementation of outpatient commitment but for its irrelevance.

Like most other states, Massachusetts revised its mental health statute in the early 1970's.²⁹⁸ A new civil commitment standard of "danger

295. *Youngberg v. Romeo*, 457 U.S. 307, 314-15 (1982).

296. See Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 RUTGERS L.J. 595, 632-33 (1983).

297. This was precisely the consequence of creating a comprehensive system of community services in western Massachusetts, pursuant to a consent decree which provided an entitlement to care in the least restrictive alternative. For a brief discussion of the consent decree, see *Brewster v. Dukakis*, No. 76-4423-F (E.D. Mass. Dec. 6, 1978), reprinted in 3 MENTAL DISABILITY L. REP. 45 (1979), enforced, 544 F. Supp. 1069 (D. Mass. 1982), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986); see also *infra* text accompanying notes 298-324.

298. A study commission reviewed statutory reforms in several other jurisdictions and made recommendations to the legislature. See Walker, *Mental Health Law Reform*, 53 B.U.L.

to self or others" replaced the more lenient criteria of "in need of care and treatment."²⁹⁹ A requirement that a person could not be hospitalized unless the institution was the least restrictive alternative was inferred by court decision and subsequently incorporated in regulations and district court rules.³⁰⁰

Extensive procedural requirements were established governing emergency detention, initial commitment and recommitment, and periodic review processes.³⁰¹ Significant substantive rights for institutional residents were also incorporated into the statutory revision.³⁰² The legislation did not provide for outpatient commitment. In fact, trial courts were explicitly limited to either committing a person to an institution or releasing him.³⁰³ However, the statute and subsequent regulations authorized administrative transfers and conditional discharge through several classifications of "visit status."³⁰⁴

REV. 986 (1973). The commission's proposal was subsequently enacted. 1970 Mass. Acts 888 (codified as amended at MASS. GEN. L. ch. 123 (1984)).

299. The statute uses the term "likelihood of serious harm" which is defined as:

(1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

MASS. GEN. L. ch. 123, § 1.

300. *Gallup v. Alden*, 57 Mass. App. Dec. 41 (Dist. Ct. 1975); see also *Commonwealth v. Nassar*, 380 Mass. 908, 917-18, 406 N.E.2d 1286, 1291 (1980). The *Nassar* court also held that the prospective harm must be imminent. 380 Mass. at 916-17, 406 N.E.2d at 1291. The guarantee of care in the least restrictive alternative is also reflected in other portions of the statute, MASS. GEN. L. ch. 123, § 4, and in the regulations of the Massachusetts Department of Mental Health, 104 MASS. REGS. CODE tit. 104, § 3.11 (1985). Even the courts have incorporated this mandate in their procedural instructions to judges who hear commitment matters. See DISTRICT COURT STANDARDS OF JUDICIAL PRACTICE § 1:02 (1979).

301. MASS. GEN. L. ch. 123, §§ 5, 7, 8, 12.

302. *Id.* §§ 23-25. These rights include, among others, standards and procedures governing restraint, the right to refuse shock treatment and lobotomy, privacy, access to visitors and mail, control of personal property, and a presumption of competency. See also *id.* ch. 111, § 70E (patients' bill of rights); MASS. REGS. CODE tit. 104, §§ 3.00-3.20.

303. *Northampton State Hosp. v. Moore*, 369 Mass. 957, 336 N.E.2d 856 (1974) (court not empowered to order community treatment). Massachusetts is unique in being one of only a few jurisdictions which has no explicit provision or even ambiguous authority for judicially-ordered community care. See *infra* Appendix.

304. MASS. REGS. CODE tit. 104, § 3.14. Decisions concerning visits are solely within the discretion of the superintendent. The length of time may vary from eight days to a year. No standards or procedures govern the revocation or modification of this form of conditional release, which may create a constitutional infirmity. See *supra* text accompanying notes 215-19.

Transfers are governed by MASS. GEN. L. ch. 123, § 3. Some process, although no substantive guidance, is incorporated in this section.

The implementation of this new commitment scheme resulted in a substantial depopulation of state facilities. Between 1970 and 1979, the census of Massachusetts' public mental hospitals plummeted from nearly 13,000 to roughly 3500.³⁰⁵ This decrease followed an earlier halving of the hospital census which occurred primarily through the institutional transferring of almost 8000 elderly persons to nursing homes between 1966 and 1973.³⁰⁶ Few community programs or support services were established during this period. While some of the released residents went home to adequate but unsupported living arrangements, others had literally nowhere to go. Up to this point the Massachusetts model mirrored the experience in most states.

Despite the enactment in 1966 of a statute which required the Commonwealth to create a "comprehensive system of community mental health and mental retardation services" in each of the state's forty catchment areas,³⁰⁷ little progress was made in implementing this mandate. Then a federal class action lawsuit was brought to enforce its promise, as well as that of other federal statutes and constitutional entitlements. The case was settled two years later by a consent decree in which Massachusetts agreed to establish and maintain an adequate number of residential programs and nonresidential services to meet the individual needs of all plaintiff class members.³⁰⁸ The action represented an entitlement for all current and future residents of the Northampton State Hospital, the public institution which served western Massachusetts. The decree specified in extraordinary detail the number, type, cost and capacity of all services, with flexibility for modification if circumstances changed or further planning was necessary.³⁰⁹

305. M. DUKAKIS, COMPREHENSIVE PLAN TO IMPROVE SERVICES FOR CHRONICALLY MENTALLY ILL PERSONS 7 (Final Report of the Mental Health Action Project 1986).

306. *Id.*

307. Massachusetts drafted its own community mental health legislation to mirror that passed by the federal government just three years earlier. 1966 Mass. Acts 735 (codified as amended at MASS. GEN. L. ch. 19 (1984)).

308. See *Brewster v. Dukakis*, No. 76-4423-F (E.D. Mass. Dec. 6, 1978), reprinted in 3 MENTAL DISABILITY L. REP. 45 (1978), enforced, 544 F. Supp. 1069 (D. Mass. 1982), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986). The decree contained a list of principles relevant to the creation of a community system of care and a set of specific commitments by the state defendants governing the establishment of services. Additional provisions on Individual Service Plans, program standards, personnel and training, monitoring and evaluation, and hospital conditions and placement procedures were also incorporated in the decree.

309. Twelve residential and 13 nonresidential program models were designed. Each included staffing patterns, utilization projections, unit and program costs, and phase-in expenses. The number of clients to be served by each model was determined by matching the needs of 47 client clusters, that were derived from individual clinical assessments, with the characteristics of each program type.

Eight years later, the system required by the decree was mostly implemented, although several key components have remained unfinished. Compared to the rest of the Commonwealth, western Massachusetts has a vastly more developed capability to offer community mental health care.³¹⁰ The contrast is even more glaring when the focus is narrowed to services for people with severe or long term mental illness, the class for whom new programs were established under the decree. Each of the five catchment areas in this region, with an average population of 150,000 citizens, has a range of staffed residential programs which vary in intensity and flexibility and which serve over 120 persons in small apartment units. No residence accommodates more than four persons. Many have special capabilities for assisting elderly persons with medical needs, adolescents and people also labeled mentally retarded or behaviorally challenging. Each area also has a full complement of nonresidential services, including a clinical assessment team, service coordinators to develop and monitor treatment plans, a twenty-four hour mobile crisis intervention program with at least a six-bed residential shelter for temporary living, case managers for most clients, vocational training, day treatment, medication and counselling/therapy services.

The implementation of this system of care has decreased the census of the state hospital by seventy percent and reduced admissions by more than fifty percent. Only a few persons with lengths of stay exceeding two years are still institutionalized at Northampton State Hospital. The current system meets virtually all of the relevant measures of comprehensiveness described in the literature.³¹¹ By most accounts, few persons are still institutionalized in western Massachusetts or are at risk of hospitalization as a result of a lack of an appropriate, less restrictive alternative.

All community services in Massachusetts are purely voluntary. Regulations promulgated pursuant to the decree and eventually extended throughout the state require informed consent prior to admission to a community program.³¹² Consent is similarly mandated for other non-

310. A coalition of consumers, families, advocates, providers and public union employees initiated the Massachusetts Equity Project to address this imbalance and attempt to promote the standard attained in western Massachusetts throughout the Commonwealth. This project analyzed each of the 35 catchment areas outside of western Massachusetts against the consent decree standard in five consolidated program configurations. The results were dramatic. The cost of achieving an equal level of services throughout the state exceeded \$154 million. See *Mental Health Services Equity Project: A Report to the Massachusetts State Legislature* (1985).

311. See generally COMMITMENT GUIDELINES, *supra* note 11, at 421-41; LRA REPORT, *supra* note 11, at 329-71; see also Stein & Test, *supra* note 85.

312. The regulations govern all community mental health programs operated, funded or otherwise licensed by the Massachusetts Department of Mental Health. They are comprised

residential care and all medication.³¹³ Protective provisions are included for persons lacking the capacity to consent.³¹⁴ Significant restrictions exist on a service provider's ability to discharge a client for noncompliance with program rules or the expectations of professionals.³¹⁵ Finally, extensive due process regulations have been issued under the decree which govern the planning, acceptance, delivery and modification of community treatment, modeled after the procedures that apply to special educational plans.³¹⁶

No formal study of this new community service system has ever been undertaken. However, statistical data and widely held views indicate that outpatient commitment would probably produce little, if any, benefit and would likely result in substantial detriments.³¹⁷ Few inpa-

of four sections: MASS. REGS. CODE tit. 104, § 15.03 (client rights/dignity); *id.* § 16.00 (individual service plans); *id.* § 17.00 (program standards); and *id.* § 18.00 (licensing procedures and enforcement). The client dignity component is extensive. It includes sections on general principles, civil rights, mistreatment, medication, restraint and seclusion, labor, personal funds and property, guardianship and protective services, consent, human rights committees, and program responsibilities with respect to client termination. *Id.* § 15.03. See *Community Residential Alternatives: New Regulations in Massachusetts*, 4 MENTAL DISABILITY L. REP. 125 (1980).

313. MASS. REGS. CODE tit. 104, § 15.03(11)-(12).

314. *Id.* § 15.03(10). In limited circumstances, where the decision is deemed routine, a program director may consent on behalf of a client incapable of making an informed decision. This informal procedure was incorporated so that a temporary guardian need not be appointed to consent to the release of information necessary for protecting the client's rights or to gain access to a limited amount of personal funds. *Id.* §§ 15.03(8)(d)(3), 15.03(9)(b)(6).

315. *Id.* § 15.04(2)(d)(1)-(5). A person may only be evicted from a program for acting in a manner which seriously disregards the rights of others. Termination cannot proceed before all available alternatives have been explored and until the procedures for modification of treatment plans (including notice, meeting, decision, and appeal) have been exhausted, except in cases of emergencies. Individuals can never be expelled from a program for exercising a right protected by the regulations including the right to refuse treatment. *Id.*

316. *Id.* § 16.00.

317. Clinicians and directors of programs in western Massachusetts concur that involuntary treatment is both unnecessary and unwise. The executive director of the largest outpatient clinic in Holyoke, which serves over a thousand individuals at a given time, felt that court-ordered treatment would complicate the clinic's task, would promote greater client resistance, and would seriously "damage what we have built" over several years. Interview with Robert Dranka, Executive Director of Crossroads, Inc., in Holyoke, Massachusetts (Aug. 26, 1986). The program's success is based upon a flexible approach which emphasizes clinical staff conducting intensive outreach efforts in the community. It is estimated that over 70% of the current clients initially resisted mental health care but gradually were engaged by the program's supportive and respectful efforts. *Id.*

An administrator of the largest community agency in rural Berkshire County acknowledged that subtle pressure on resistant clients may be useful for encouraging participation in mental health treatment, but that explicit coercion would be both dysfunctional and even dangerous. Given the absence of any clinical capacity to actually compel treatment or carefully monitor the effects of coerced care, judicially-ordered interventions would do little more than create an illusion of control that might be intimidating but not effective. Interview with Ray-

tient admissions would be diverted if courts could immediately commit people to crisis shelters.³¹⁸ It is improbable that many current inmates of the state hospital would be discharged if commitment to a community residence was an option.³¹⁹ Consent decree planners considered and rejected this approach several times. Significant licensing and building code problems,³²⁰ combined with the stated opposition of local officials, budget analysts, service providers, mental health professionals, consumers and the general public foreclosed this model.

Little appears to have been sacrificed in terms of client needs, treatment compliance or humane care by this decision. Conversely, substantial advantages accrue from the offer of purely voluntary services to people labeled mentally ill. For the most part, they accept the offer willingly; to the extent they do not, the reason can often be traced to problems in the quality of services provided or to an intimidating atmosphere which pervades the program. Of course, some individuals with

mond P. Brien, Executive Director of the Berkshire Mental Health Center, in Pittsfield, Massachusetts (Aug. 18, 1986).

318. Several clinicians who directed prescreening programs indicated that the only advantage of involuntary treatment is the ability to serve persons currently dangerous and totally unwilling to accept care. All others presently are assisted by voluntary crisis programs, which respond to over 1300 calls per month and see over 200 individuals every month in each of the five catchment areas in western Massachusetts. Given the risk that a person may escape, it is not clear that local communities would accept court-ordered involuntary commitments to crisis shelters. Building and licensing code issues would also complicate the program's structure. Interview with Barbara Stefferud, Clinical Director, and Paul Wagner, Executive Director, Mt. Tom Institute, in Holyoke, Massachusetts (Aug. 22, 1986).

319. Residential agency directors could not identify a single person at the Northampton State Hospital for whom involuntary treatment would make a significant difference in the program's capability to provide care. On the contrary, they saw an inverse relationship between the degree of coercion and the probability of successful integration into the community. Interview with Susan Stubbs, Executive Director, and George Fleischner, Program Director, Valley Programs, Inc., in Northampton, Massachusetts (Aug. 18, 1986). As one administrator stated, "The point is to create good programs rather than to commit people to bad ones." *Id.* (quoting George Fleischner).

Most agency staff agreed that if there were any theoretical benefits of compulsory community care, these were limited to a very small number of clients (less than five percent) and presented almost impossible monitoring problems. Interview with Marjorie Cohan, Clinical Director of Meridian Associates, in Pittsfield, Massachusetts (Aug. 18, 1986). Nevertheless, despite the unavailability of outpatient commitment for over six years, the director felt that no clients served by the program would have avoided hospitalization if involuntary community treatment was an option. *Id.*

320. The costs of safety are rarely considered when outpatient commitment proposals are discussed. For a person to be involuntarily committed to a community program, the facility may need to meet especially restrictive building and fire codes. In Massachusetts, compliance with these standards would be prohibitive since they require institutional construction and elaborate fire protections. The benefits of small homes would be sacrificed to the design features of hospitals and similar facilities, thereby reinforcing the environmental transference of involuntary psychiatric treatment.

serious disabilities will still have nothing to do with this limited system of care. Several might well benefit from support and structured opportunities, but few if any would qualify as compliant under outpatient commitment criteria.³²¹ Thus, a compulsory treatment scheme would affect almost no one in western Massachusetts. Instead, it would convert an unconditioned offer of support into a judicially-managed regimen of interference.

Western Massachusetts is hardly the ideal community mental health system. Problems concerning the capacity, accessibility, quality and individualization of services abound. Nevertheless, it is perhaps the most comprehensive system in the nation that serves a large geographic region.³²² By establishing an entitlement to community services and a range of mental health programs, it addresses the two most critical problems discussed above.³²³ By precluding models for involuntary community treatment, it eliminates the need to overcome the remaining implementation obstacles to outpatient commitment.³²⁴ Finally, by offering only voluntary services, it creates a powerful incentive for handicapped persons to participate in community programs.

VII. CONCLUSION

Outpatient commitment is neither well developed nor well considered. There is not even a common understanding of its purpose or provisions. To some it suggests a possibility for avoiding unnecessary institutionalization and providing treatment in more humane, community settings. To others it represents an expansion of the state's *parens patriae* authority, a return to an era when the perception of a disability and the professionally determined need for treatment justified compulsory clinical intervention. To a few naive observers, it promises a panacea for homelessness, a remedy for the failures of deinstitutionalization and a means to save the stubborn resisters of psychiatric treatment.

321. Compliant, at least under most state statutes, means willing to participate in community services. See *supra* note 244. In practice, it may mean urged, pressured or cajoled to participate under the informal but not so subtle threat of rehospitalization. Where the pressure becomes an actual threat of reinstitutionalization and the consequential involuntary admission contravenes statutory standards, then this indirect approach to compulsory treatment becomes a lawless abuse of due process. This appears to be the approach adopted by a psychiatrist who invented his own outpatient commitment scheme in western Massachusetts. See Geller, *supra* note 239.

322. See *Brewster v. Dukakis*, 520 F. Supp. 882 (D. Mass. 1981); see also Okin, *Brewster v. Dukakis: Developing Community Services Through Use of a Consent Decree*, 141 AM. J. PSYCHIATRY 786 (1984).

323. See *supra* text accompanying notes 233-37 & 292-97.

324. See *supra* text accompanying notes 238-97.

Outpatient commitment is not a legally justified expression of the *parens patriae* power because it is not limited to the historical purpose of protecting the physical safety or property of incompetent persons. Nor is it consistent with the least restrictive alternative principle, since it sanctions rather than curtails the deprivation of individual liberty. Shifting the locus where the government restricts the fundamental guarantees of physical freedom, choice and privacy neither legitimizes the deprivation nor creates a compelling justification for a particular form of coercion.

Outpatient commitment is not feasible. A host of obstacles, most notably the lack of appropriate community mental health programs to provide the court-ordered care, preclude its effective implementation. At best it is a questionable theory in search of a feasibility plan.

Outpatient commitment is not necessary. Existing provisions for administrative discharge and transfer to community services provide sufficient flexibility to respond to the few cases in which involuntary community treatment of committed persons might have a significant benefit. In areas where community mental health services are provided responsively, accessibly, adequately and voluntarily, a scheme for compelling treatment is superfluous and potentially harmful. The system of care recently established in western Massachusetts demonstrates that quality services, not forced treatment, is the most promising solution to the current mental health crisis.

Finally, outpatient commitment is primarily a guise for substantially modifying the criteria for state-imposed psychiatric intervention. The creation of a dual standard for institutional and community commitment is a disfavored approach which raises grave constitutional objections. Although a lower threshold for forced community care may answer some of the practical issues of necessity, this rationale multiplies rather than limits the conceptual problems. Yet absent a more lenient community commitment standard, few, if any, people will likely qualify for the beneficence of this new form of coercion. With most of the public attention and clinical fervor directed not to the myriad of implementation obstacles, but rather to the renewed possibility of forcibly treating those who present no immediate physical danger to anyone, it is beyond dispute that the true lure of outpatient commitment is not how or where, but who. Ultimately, it is an attempt to make things better which can only make matters worse.

APPENDIX

Table 1

Involuntary Outpatient Commitment (IOC)
Statutory Authorizations, Standards, Definitions, and Prerequisites

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC	Disposition
Alaska	After a hearing, the court may commit respondent to a treatment facility. § 47.30.755(a). If the court finds that there is a less restrictive alternative available, the court may order the less restrictive alternative for a period not to exceed 90 days. <i>Id.</i> at (b).			Acceptance by the alternative treatment program. § 47.30.755(b).	
Arizona	The court may order respondent to undergo outpatient or combined inpatient and outpatient treatment if the involuntary civil commitment standard is met. § 36-540.B.	The court must determine that patient (a) does not require continuous inpatient hospitalization; (b) will be more appropriately treated in an outpatient treatment program or in a combined inpatient and outpatient treatment program; (c) will follow a prescribed outpatient treatment plan; and (d) will not likely become dangerous or suffer more serious physical harm or serious illness if he follows a prescribed outpatient treatment plan. § 36-540.B.1.	Any treatment program not requiring continuous inpatient hospitalization. § 36-501.19.	The court must be presented with and approve a written treatment plan. § 36-540.B.2.	

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Arkansas	The court may order outpatient treatment as opposed to hospitalization at the 45 or 180 day commitment hearing for a period not to exceed 6 months if the court finds that the involuntary commitment requirements are met. § 59-1415(c).	The court shall make a determination whether clear and convincing evidence has been presented that the person sought to be committed only becomes homicidal, suicidal, or gravely disabled when not regularly taking the medication previously prescribed for his condition. § 59-1409.		The petition for involuntary commitment shall contain a specific prayer for commitment of the person to a hospital or for outpatient treatment and set forth the necessary allegation if outpatient treatment is sought. § 59-1404.B.(iv),(v). The court must further find that the person has been involuntarily committed within the last 2 years; and that the mental illness, disease, or disorder from which the patient is suffering is one that has been treated successfully by medication in the past. § 59-1409.
Delaware	The court shall consider all available alternatives, including inpatient confinement at a hospital, and shall order such disposition as imposes the least restraint upon the involuntary patient's liberty and dignity consistent both with affording treatment and care and with protecting the safety of the patient and the public. § 5010(2).			
District of Columbia	The court may order hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or of the public. § 21-545(b).			

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Georgia	If the court finds that an alternative outpatient program exists, it shall order the patient to comply with the program. If the court finds, based on the evidence, that the accomplishment of the treatment goals for the patient requires some limited period of hospitalization followed by outpatient treatment in a community mental health center, the court may so order. § 37-3-81(c).			The court shall determine, based upon either the individualized service plan prepared by the physician responsible for treatment of the patient at the facility (in conjunction with and in agreement with the physician to be responsible for the outpatient care) or proposed by the physician chosen by the patient, whether there exists a program of treatment for the individual which does not require hospitalization. The court must find that such a program meets the requirements for an individualized service plan, and that under such a program the danger presented by the patient to himself or others can be safely controlled. § 37-3-81(c).
Hawaii	A person may be ordered to obtain involuntary outpatient treatment if the family court finds that he or she meets the involuntary outpatient commitment criteria. § 334-127(b).	The person is suffering from a severe mental disorder or from substance abuse and, based on the person's treatment history and current behavior, is now in need of treatment in order to prevent a relapse or deterioration which would predictably result in the person becoming imminently dangerous to self or others, and the person's current mental status or the nature of the person's disorder limits or negates the person's ability to make an informed decision to voluntarily seek or comply with recommended treatment. § 334-121(1), (4), (5).	Medication specifically authorized by court order; individual or group therapy; day or partial day programming activities; services and training, including educational and vocational activities; supervision of living arrangements; and any other services prescribed to either alleviate the person's disorder or disability, to maintain semi-independent functioning, or to prevent further deterioration that may reasonably be predicted to result in the need for hospitalization. § 334-122.	The family court must find that the person is capable of surviving safely in the community with available supervision from family, friends, or others; and at some time in the past: (a) has received inpatient hospital treatment for a severe mental disorder or substance abuse, or (b) has been imminently dangerous to self or others as a result of a severe mental disorder or substance abuse; and (c) there is a reasonable prospect that the outpatient treatment ordered will be beneficial to the person. § 334-121(2), (3), (6).

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Illinois	The court shall consider alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization. § 3-811. <i>See also</i> § 3-812.			The facility director or other person shall prepare a report including information on the appropriateness and availability of alternative treatment settings, a social investigation of the respondent, a preliminary treatment plan, and any other information which the court may order. § 3-810. Alternative treatment shall not be ordered unless the program being considered is capable of providing adequate and humane treatment which is appropriate to the respondent's condition. § 3-812(e).
Iowa	If the chief medical officer's recommendation states that the respondent is seriously mentally impaired and in need of treatment but does not require full-time hospitalization, the court may enter an order directing the respondent to submit to treatment on an outpatient or other appropriate basis. § 229.14(3). If an individual is found to be requiring treatment, the court may order the individual to undergo a program of treatment which is an alternative to hospitalization or a program of combined hospitalization and alternative treatment. § 330.1468(2)(c), (d), (3)(c), (d).			
Michigan				The court shall review a written report, prepared not more than 15 days before the hearing, assessing the current availability and appropriateness for the individual of treatment programs other than hospitalization, including alternatives available following an initial period of court ordered hospitalization. The court shall inquire as to the desires of the individual regarding alternatives to hospitalization. § 330.1469(1), (2); <i>see also id.</i> at (6).

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Mississippi	Alternatives to commitment to inpatient care may include, but shall not be limited to: voluntary or court ordered outpatient treatment with specific reference to a treatment regimen, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, or the provision of home health services. § 41-21-73(4). The court shall order the respondent to be placed in the care and custody of his relative or guardian or some other appropriate place other than an institution; or order outpatient treatment; or make some other appropriate order for treatment.		See "Statutory Authorization," this table, Column 1.	
Montana	The court shall order the respondent to be placed in the care and custody of his relative or guardian or some other appropriate place other than an institution; or order outpatient treatment; or make some other appropriate order for treatment. § 53-21-127(2)(a)(ii), (iii), (iv). The board shall consider all treatment alternatives, including any treatment, consultation, chemo-therapy or any other program or set of conditions. Full time inpatient hospitalization or custody shall be considered a treatment alternative of last resort. § 83-1038.		See "Statutory Authorization," this table, Column 1.	
Nebraska	The board shall consider all treatment alternatives, including any treatment, consultation, chemo-therapy or any other program or set of conditions. Full time inpatient hospitalization or custody shall be considered a treatment alternative of last resort. § 83-1038.			
New Hampshire	The court may order the respondent to submit to some form of treatment other than inpatient treatment on an involuntary basis. § 135-B:37.			The court may overrule the recommendation of the examining psychiatrist for IOC only after the court finds that treatment other than involuntary admission would not be in the best interest of the patient or community. § 135-B:37.

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
New Mexico	If the court finds that the client meets the mentally ill standard but does not require residential care, it may order the client to undergo such non-residential treatment as may be appropriate and necessary. § 43-1-11.D; <i>see also id.</i> at C.			
North Carolina	If the court finds that the respondent meets the IOC standard it may order outpatient commitment. § 122-58.8(a)(2); <i>see also</i> § 122-58.8(b)(1).	Clear, cogent, and convincing evidence that the respondent is mentally ill; is capable of surviving safely in the community with available supervision from family, friends, or others; is in need of treatment to prevent further disability or deterioration which would result in dangerousness; and the respondent has limited ability to make informed decisions to voluntarily seek or comply with recommended treatment. § 122-58.4(c)(2); <i>see also</i> § 122-58.4(c)(2)d.	Outpatient treatment may include medication; individual or group therapy; day or partial day programming activities; services and training including educational and vocational activities; supervision of living arrangements; and any other services to alleviate the person's illness, to maintain semi-independent functioning, or to prevent deterioration that may lead to inpatient hospitalization. § 122-58.2(8).	The court shall make findings of fact as to the availability of outpatient treatment. § 122-58.8(a)(4).
North Dakota	The court shall order the respondent to receive whatever treatment other than hospitalization that is appropriate for a period of 90 days. § 25-03.1-21.			The court shall review a report assessing the availability and appropriateness of treatment programs other than hospitalization which has been prepared and submitted by the state hospital or treatment facility. The court must find that the alternative program is adequate to meet the respondent's treatment needs and is sufficient to prevent harm or injuries which the individual may inflict upon himself or others. § 25-03.1-21.

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Oklahoma	The court may order the individual to receive whatever treatment other than hospitalization that is appropriate. § 54.9.8.		Programs other than hospitalization to be considered shall include, but not be limited to: outpatient clinics, extended care facilities, nursing homes, sheltered care arrangements, home care and homemaker services, and other treatment programs or suitable arrangements. § 54.6.6.	The court must find that a program other than hospitalization is adequate to meet the individual's treatment needs and is sufficient to prevent injury to the individual or to others. § 54.9.8.
Oregon	The court may order that the mentally ill person be conditionally released and placed in the care of his legal guardian, relative or friend during the period of commitment not to exceed 180 days. § 426.130(2).			The legal guardian, relative or friend requesting custody must show that he is able to care for the mentally ill person and that there are adequate financial resources available for the care. The care must be provided in a place satisfactory to the judge. § 426.130(2). Investigation of treatment alternatives shall include considerations of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. § 7304(f).
Pennsylvania	The court shall enter an order directing treatment in an approved facility as an inpatient or an outpatient, or a combination of such treatment. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. § 7304(f).			
South Carolina	The court shall order inpatient or outpatient treatment at a mental health facility. § 44-17-580(2).			
South Dakota	Board of Mental Illness may order the individual to undergo either inpatient or outpatient treatment at a community mental health center. § 27A-9-18.			

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Texas	The judge may enter an order requiring the person to participate in mental health services other than inpatient care. § 5547-50(d)(2); <i>see also</i> § 5547-51(d)(2).		Alternatives include but are not limited to programs of community mental health and mental retardation centers and services provided by a private psychiatrist or psychologist.	
Vermont	If the court finds that a treatment program other than hospitalization is adequate to meet the person's treatment needs, the court shall order the person to receive whatever treatment other than hospitalization that is appropriate. § 7618(a); <i>see also</i> § 7627(b)(3). Outpatient or partial hospitalization shall be preferred to inpatient treatment. § 7703(a).			The court shall order testimony by an appropriate representative of a hospital, community mental health agency, public or private entity or agency or suitable person, who shall assess the availability and appropriateness for the individual of treatment programs other than hospitalization. § 7617(d).
Virginia	A person who meets the criteria for involuntary treatment but who is not in need of involuntary hospitalization shall be subject to court-ordered outpatient treatment, day treatment in a hospital, night treatment in a hospital, referral to a community mental health clinic, or other such appropriate treatment modalities as may be necessary to meet the needs of the individual. § 37.1-67.3.		<i>See</i> "Statutory Authorization," this table, Column 1.	

(continued)

Table 1 (continued)

State	Statutory Authorization	IOC Standard	Definition	Prerequisites to IOC Disposition
Washington	After a probable cause hearing, if the court finds that treatment in a less restrictive setting is in the best interest of the respondent or others, it shall order an appropriate less restrictive course of treatment for no longer than 14 days. § 71.05.240. See also § 71.05.320(1) for IOC following hearing on additional treatment.			If an involuntary less restrictive alternative is sought, the petition shall state facts that support the finding that such person meets the involuntary treatment standard and shall set forth the less restrictive alternative proposed by the facility. § 71.05.230(4).
Wisconsin	The court shall order commitment to the care and custody of the appropriate board or, if inpatient care is not required, order commitment to outpatient treatment under the care of such board. § 51-20(13)(a)(3).			The court must find that the dangerousness of the subject individual is likely to be controlled with appropriate medication administered on an outpatient basis. § 52-20(13)(dm).

Table 2
Involuntary Outpatient Commitment (IOC)
Prehearing and Hearing Procedures

State	Pre-Hearing Examination and Recommendations	Pre-Hearing Compliance Monitoring	Court Hearing
Arizona	A person being evaluated on an outpatient basis will not remain in the facility overnight but will be examined during the usual outpatient working hours of the facility. The evaluation will be completed not later than the tenth day after the first appointment, excluding Saturdays, Sundays, and holidays. § 36-530.C. The petition for court-order treatment shall be accompanied by the affidavits from two physicians which describe in detail the behavior which indicates the person meets the involuntary civil commitment standard. § 36-533.B.	If a person who has been directed by the court order to appear for an outpatient evaluation does not complete the appointments scheduled, the evaluation agency shall notify the court and, if appropriate, request that the court order the patient taken into custody for evaluation on an inpatient basis. § 36-530.D.	The two physicians who performed the evaluation of the patient shall testify at the hearings. The physicians shall testify as to placement alternatives appropriate and available for the care and treatment of the patient. § 36-539.B. The court shall file a report as part of the court record on its findings of alternatives for treatment. § 36-540.I.

(continued)

Table 2 (continued)

State	Pre-Hearing Examination and Recommendations	Pre-Hearing Compliance Monitoring	Court Hearing
Hawaii	If the subject of the petition does not consent to examination by a psychiatrist appointed by the court, and the family court finds sufficient evidence to believe that the allegations in the petition are true, the family court may order the commitment of the subject to a psychiatric facility for examination. If the recommended outpatient treatment includes medication, the psychiatrist shall be required to testify to the types or classes of medication(s) which should be authorized, and describe the physical and mental beneficial and detrimental effects of such medication(s). § 334-126(g).		No subject of the petition shall be ordered to receive involuntary outpatient treatment unless at least one psychiatrist testifies in person at the hearing who has personally examined the subject within the time period commencing five calendar days before the filing of the petition and ending at the time of the psychiatrist's testimony. The psychiatrist's testimony shall state the facts which support the allegation that the subject meets all the criteria for involuntary outpatient treatment, the recommended outpatient treatment, and the rationale for the recommended outpatient treatment. § 334-126(g). Before entry of an alternative treatment order, the court shall have received a written report or oral testimony from the agency or independent mental health practitioner who is to supervise the individual's alternative treatment program as to the capability of the agency or independent mental health practitioner to supervise the alternative treatment. § 330.1469(6). The court shall consider and describe in its order what alternatives for treatment are available, what alternatives were investigated, and why the investigated alternatives were not deemed suitable. § 53-21-127(2)(c).
Michigan			
Montana			

(continued)

Table 2 (continued)

State	Pre-Hearing Examination and Recommendations	Pre-Hearing Compliance Monitoring	Court Hearing
North Carolina	<p>If the respondent meets the IOC criteria, the physician shall so indicate on the physician's examination report, release the respondent pending the district court hearing, and notify the court of his findings. § 122-58.6(a). The examining physician or the proposed outpatient treatment physician may prescribe to the respondent the reasonable and appropriate medication and treatment pending the district court hearing. § 122-58.6A(b). In no event may a respondent be physically forced to take medication or forcibly detained for treatment pending a district court hearing. § 122-58.6A(c).</p> <p>If possible, the court shall allow the person to remain at home or other place of residence pending an ordered examination or examinations and to return to such person's home or other place of residence upon completion of the examination or examinations. § 54.5. A precommitment examination shall include, but is not limited to, a study of the individual's family and community situation and a list of available forms of care and treatment which may serve as an alternative to admission to a hospital. § 54.6.4, 5.</p>	<p>If a respondent becomes dangerous to himself or others pending a district court hearing on outpatient commitment, new proceedings for involuntary patient commitment may be initiated. § 122-58.6A(c). If the examining physician is different from the proposed outpatient treatment physician or center, and the respondent fails to appear for examination by the outpatient physician or center, the court shall order the respondent into custody for examination. § 122-58.6A(a).</p>	<p>A hearing shall be held in district court within 10 days of the day the respondent is taken into custody. § 122-58.7A:1(e). Certified copies of reports and findings of qualified physicians and medical records of previous and current treatment are admissible in evidence. § 122-58.7A:1(c). The court shall record the facts which support its findings and shall indicate who is responsible for the management and supervision of the respondent's outpatient treatment. § 122-58.7A:1(h). If the court offers inpatient commitment for a respondent who is under a prehearing IOC order, the IOC is terminated. § 122-58.8(a)(1).</p>
Oklahoma	<p>If possible, the court shall allow the person to remain at home or other place of residence pending an ordered examination or examinations and to return to such person's home or other place of residence upon completion of the examination or examinations. § 54.5. A precommitment examination shall include, but is not limited to, a study of the individual's family and community situation and a list of available forms of care and treatment which may serve as an alternative to admission to a hospital. § 54.6.4, 5.</p>		
Texas			<p>The judge may hear additional evidence regarding alternative settings for care. § 5547-51(d).</p>

(continued)

Table 2 (continued)

State	Pre-Hearing Examination and Recommendations	Pre-Hearing Compliance Monitoring	Court Hearing
Washington	Each person involuntarily admitted to an evaluation and treatment facility shall be examined and evaluated by a licensed physician and a mental health professional and shall receive such treatment and care as his condition requires including treatment on an outpatient basis for the period that he is detained. § 71.05.210. A petition for a continuation of treatment shall be supported by affidavits signed by two mental health professionals. The affidavits shall describe any less restrictive treatments which are alternatives to detention that are available and shall state the willingness of the affiant to testify in subsequent judicial proceedings. § 71.05.290(2).	The court may release the subject individual pending the full hearing. The court may issue an order stating the conditions under which the individual may be released from detention pending the final hearing. If acceptance of treatment is made a condition of such release, the subject individual may elect to accept the conditions or choose detention pending the hearing. The court order may state the action to be taken upon information of breach of such conditions. § 51-20(8)(c).	A final hearing must be held within 30 days of order, if the individual is released pending final hearing. § 51-20(8)(a).
Wisconsin			

Table 3
Involuntary Outpatient Commitment (IOC)
Disposition, Liability, Rehearing, and Release

State	Disposition and Treatment	Liability of Treatment Providers	Early Release Procedures	Duration of IOC Status
Arizona	<p>If the court finds by clear and convincing evidence that the proposed patient meets the involuntary civil commitment standard, it may order him to receive outpatient or combined inpatient and outpatient treatment for a period not to exceed 365 days.</p> <p>§ 36-540.A.1., 2., C. The period of inpatient treatment under a combined treatment order shall not exceed the maximum period allowed for an order for inpatient treatment. <i>Id.</i> at C.</p> <p>If the family court finds by clear and convincing evidence that the person meets the IOC criteria, the court shall order outpatient treatment for a period of not more than 180 days and specify the outpatient treatment which the respondent is to obtain. If the court finds by clear and convincing evidence that the beneficial mental and physical effects of recommended medication(s) outweigh the detrimental mental and physical effects, if any, the order may authorize types or classes of medication(s) to be included in outpatient treatment in the discretion of the outpatient treatment psychiatrist.</p> <p>§ 334-127(b).</p>	<p>The medical director or any person, or agency or organization used by the medical director to supervise the terms of an outpatient treatment plan shall not be held civilly liable for any acts committed by a patient while on outpatient treatment if the medical director, person, agency or organization has in good faith followed the requirements of this section. § 36-540.K.</p>	<p>Patient may be released from treatment prior to the expiration of the period ordered by the court if, in the opinion of the medical director of the mental health treatment agency, the patient no longer is, as a result of a mental disorder, a danger to others, a danger to self or gravely disabled. § 36-541.01.A. A patient receiving court ordered treatment or any person acting on his behalf may request the patient's early release. § 36-546.A.</p>	<p>See "Disposition and Treatment," this table, column 1.</p>
Hawaii	<p>An outpatient treatment psychiatrist shall commence early discharge procedure if he finds that the subject no longer meets the criteria for involuntary outpatient treatment. The clerk of the court shall notify persons whom the family court order specified of intent of early discharge. If no objection is filed within five days, the court shall enter an order of discharge. § 334-131(a), (b). Upon receipt of an objection, the court shall hold a hearing on the discharge. § 334-132. Any person may petition the family court for a discharge of an order of involuntary outpatient treatment during the period of outpatient treatment if more than sixty days after the most recent hearing involving the subject of the order. § 334-134.</p>	<p>An outpatient is automatically and fully discharged at the end of the family court ordered period unless prior to the expiration of the period any person files a petition for continued involuntary outpatient treatment. § 334-130. The court shall hold a hearing on the petition and may order the continued involuntary outpatient treatment for not more than 180 days after the date of the hearing. § 334-133.</p>		(continued)

Table 3 (continued)

State	Disposition and Treatment	Liability of Treatment Providers	Early Release Procedures	Duration of IOC Status
Illinois	The court may order the respondent to undergo a program of hospitalization or alternative treatment in a public mental health facility; in a private hospital or mental health facility if it agrees; or in a facility of the Veterans Administration if it agrees; or the court may place the respondent in the custody of a relative or other person willing and able to properly care for him. § 3-811. The initial order shall be for a period not to exceed 60 days.			If no petition is filed prior to the expiration of the initial order, the patient shall be discharged. Following a hearing the court may order a second period of hospitalization or alternative treatment not to exceed 60 days only if it finds that the patient continues to be subject to involuntary admission. Additional 180 day periods of treatment may be sought. § 3-813(a), (b).
Iowa			When in the opinion of the chief medical officer the patient no longer requires treatment or care for serious medical impairment, the officer shall tentatively discharge the patient and immediately report to the court. The court thereupon shall issue an order confirming discharge. § 229.16.	Not more than 60 days after the entry of a court order for outpatient treatment, and thereafter at successive intervals as ordered by the court (but not to exceed 90 days) so long as that court order remains in effect, the medical director of the facility treating the patient shall report to the court which entered the order. The report shall state whether the patient's condition has improved, remains unchanged, or has deteriorated, and shall indicate if possible the further length of time that patient will require treatment by the facility. § 229.15(2).

(continued)

Table 3 (continued)

State	Disposition and Treatment	Liability of Treatment Providers	Early Release Procedures	Duration of IOC Status
Michigan	If the court finds that a treatment program which is an alternative to hospitalization is adequate to meet the individual's treatment needs and is sufficient to prevent harm or injuries which the individual may inflict upon himself or herself or upon others, the court shall order the individual to receive that treatment for a period of not more than 90 days. The court may order the individual to receive combined hospitalization and alternative treatment for a period of not more than 90 days. The hospitalization portion of the order shall not exceed 60 days. § 330.1469(3), (4).		A person responsible for providing treatment to an individual ordered to undergo a program of alternative treatment <i>may</i> terminate the treatment to the individual if the provider of the treatment considers the individual clinically suitable for termination of treatment, and <i>shall</i> terminate the treatment when the individual's mental condition is such that he or she no longer meets the criteria of a person requiring treatment. § 330.1477(1). Upon termination of alternative treatment or combined hospitalization and alternative treatment, the court shall be notified by the provider of the treatment. § 330.1477(2). If the individual ordered to undergo treatment believes that the alternative treatment is not appropriate, then the individual may petition the court for a review of the order. § 330.1469(9)(d).	Not less than 14 days before expiration of an alternative treatment order, (a) if it is believed by the agency or mental health practitioner directed to supervise the alternative treatment program that the person continues to require alternative treatment, and if the person refuses to continue the alternative treatment program on a voluntary basis when the court order expires, the agency or practitioner shall petition the court for continued alternative treatment for no more than 6 months; or (b) if it is believed by the director of the hospital that the person continues to require treatment, the director shall petition the court for an order authorizing hospitalization or combined hospitalization and alternative treatment for no more than 6 months. § 330.1469(9)(a)(c). Upon expiration of the court order, any person over 18 years of age may petition the court for continued treatment of the person. § 330.1469(11).
Montana	In determining which of the dispositional alternatives to order, the court shall choose the least restrictive alternative necessary to protect the respondent and the public and to permit effective treatment. § 53-21-127(2)(c).			If following the initial commitment period, the court finds that the patient continues to suffer from serious mental illness, the court shall order commitment, custody by relatives, or outpatient therapy. No order may affect the patient's custody for more than 6 months. § 53-21-128(d).

(continued)

Table 3 (continued)

State	Disposition and Treatment	Liability of Treatment Providers	Early Release Procedures	Duration of IOC Status
North Carolina	<p>If the court finds by clear, cogent and convincing evidence that the respondent meets the IOC standard, it may order outpatient commitment for a period not in excess of 90 days. § 122-58.8(a)(2).</p> <p><i>See also</i> § 122-58(b)(a). When an IOC order is issued for a respondent held in an inpatient facility, the court may order the respondent held at the facility for no longer than 72 hours in order for the treatment facility to notify the designated outpatient treatment physician or center of the treatment needs of the respondent. § 122-58.8(a)(4). The outpatient physician is authorized to prescribe or administer reasonable and appropriate medication and treatment that is consistent with accepted medical standards. § 122-58.10A(b).</p>	<p>None of the facilities or centers, or any of the officials, staff or employees thereof, or any physician or other individual who is responsible for the management, supervision and treatment of a respondent's outpatient commitment shall be financially liable, personally or otherwise, for actions of the respondent if such entities, physicians or individuals follow accepted professional judgment, practice and standards in the management, supervision and treatment of the respondent. This immunity is in addition to any other legal immunity from liability to which these entities, physicians or other individuals may be entitled. § 122-58.8A.</p>	<p>At any time that the outpatient treatment physician finds that the respondent no longer meets the IOC criteria, the physician shall so notify the court and the case shall be dismissed. § 122-58.10A(b)(4). At any time during the term of an outpatient commitment order, a respondent may apply to the court for a supplemental hearing for the purpose of discharge from the order. § 122-58.10B(b).</p>	<p>If at the end of the initial or subsequent periods, the respondent no longer meets the IOC criteria, the physician shall so notify the clerk who shall dismiss the case. If the outpatient treatment physician determines that the respondent continues to meet the IOC criteria, he shall so notify the clerk of superior court of the county where the outpatient treatment is supervised 15 days before the end of the initial or subsequent periods of outpatient commitment. § 122-58.11A(a). The clerk shall calendar a supplemental hearing. If the respondent continues to meet the IOC criteria, the court may order outpatient commitment for an additional period not in excess of 180 days. § 122-58.11A(c).</p>
North Dakota				<p>If, at the date of expiration of an order of alternative treatment, it is believed that an individual continues to require treatment, a petition for a determination that the individual continues to require treatment may be filed with the court. § 25-03.1-21.</p>

(continued)

Table 3 (continued)

State	Disposition and Treatment	Liability of Treatment Providers	Early Release Procedures	Duration of IOC Status
Oklahoma	The court may order the individual to receive whatever treatment other than hospitalization that is appropriate for a period of 90 days, during which time the court shall continue its jurisdiction over the individual as a person requiring treatment. § 554.9.B.		The Department of Mental Health or the court may discharge a person at a time prior to the expiration of the 90-day period of alternative treatment, or any extension thereof. The Department of Mental Health shall issue a report to the court, outlining the disposition of each person, subsequent to discharge. § 54.9.C.	The Department of Mental Health or the court may discharge a person at any time prior to the expiration of the 90-day period of alternative treatment. § 54.9.C. If at the date of expiration of an order of alternative treatment it is believed that the individual continues to require treatment, a petition for a determination that the individual is a person requiring treatment may be filed. § 54.9.B.3.
Texas	The judge may enter an order requiring the person to participate in mental health services other than inpatient care, including but not limited to programs of community mental health and mental retardation centers and services provided by a private psychiatrist or psychologist. § 5547-51(d)(2).			
Vermont	The court shall order the person to receive whatever treatment other than hospitalization that is appropriate for a period of 90 days. § 7618(a).		A patient who has been ordered to receive treatment other than hospitalization may apply for discharge to the district court which originally entered the order; the court may transfer the matter to the court in which the treatment is centered or in which the patient resides. § 7801(a).	A hearing on the application for continued treatment shall be held in accordance with the procedures governing the original hearing. If the court finds that the patient is a patient in need of further treatment but does not require hospitalization, it shall order non-hospitalization for an indeterminate period. § 7621(a)(c). Applications may be made no sooner than 90 days after the issuance of an order of continued treatment or no sooner than 6 months after filing of a previous application. § 7801(a).

(continued)

Table 3 (continued)

State	Disposition and Treatment	Liability of Treatment Providers	Early Release Procedures	Duration of IOC Status
Washington	The court shall remand respondent to the custody of the department of social and health services or to a certified facility for a period of less restrictive treatment not to exceed 90 days from the date of judgment. § 71.05.320(1).			Respondent shall be released from involuntary treatment at the expiration of 90 days unless the designated mental health professional files a new petition for involuntary treatment.
Wisconsin	The court may direct in its order that the board or the department may, after a facility evaluates the subject individual and develops an appropriate treatment plan, release the individual on a conditional transfer with one of the conditions being that the individual shall take medication as prescribed by a physician and that the individual shall report to a particular treatment facility on an outpatient basis for evaluation as often as required by the director of the facility or the director's designee. § 51.20(13)(dm).			§ 71.05.320(2).

Table 4
Involuntary Outpatient Commitment (IOC)
Compliance Monitoring, Review, and Revocation

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
Arizona	<p>The court shall designate the medical director of the mental health treatment agency that will supervise and administer the patient's treatment program. The medical director shall not use the services of any person, agency or organization to supervise a patient's outpatient treatment program unless the person, agency or organization has agreed to provide such services in the individual patient's case and unless the department has determined that the person, agency or organization is capable and competent to do so. The party assigned to supervise an outpatient treatment program shall be notified at least 3 days before a referral.</p> <p>§ 36-540.D.1, 2, 3.</p>	<p>If the court determines that the patient is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate and the patient needs inpatient treatment, the court, without a hearing, and based upon the court record, the patient's medical record, the affidavits and recommendations of the medical director, and the advice of staff and physicians familiar with the treatment of the patient, may enter an order amending its original order. § 36-540.D.4.</p>	<p>Hearing not required. See "Revocation of IOC Status," this table, column 2.</p>	<p>The amended order may alter the outpatient treatment plan or compel the patient to inpatient treatment. The amended order shall not increase the total period of commitment originally ordered by the court or, when added to the period of inpatient treatment provided by the original order and any other amended orders, exceed the maximum period allowed for an order for inpatient treatment. When reporting to a treatment agency for inpatient treatment pursuant to an amended order, the patient shall be informed of his right to judicial review and his right to consult with counsel. § 36-540.D.4.</p>

(continued)

Table 4 (continued)

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
Georgia		<p>If at any time during a period of involuntary outpatient treatment the patient fails to comply with the outpatient service plan or the physician in charge of the patient's treatment determines that, because of a change in the patient's condition, the least restrictive alternative which would accomplish the treatment goals is hospitalization of the patient, then the treating physician may petition the court for an order authorizing a peace officer to take the patient into custody and to deliver him to the treatment facility pending completion of a full and fair hearing. § 37-3-82(a), (b).</p>	<p>The chief medical officer shall submit to the court of the county in which the treatment facility is located an updated individualized service plan for the patient. Copies of the custody petition shall be served upon the patient and his representatives within five days after the patient is taken into custody pursuant to such order and shall be accompanied by a copy of the updated treatment plan. No sooner than ten days and no later than 15 days after the patient is taken into custody, a full and fair hearing shall be held in the court of the county in which the treatment facility is located to determine whether or not the patient should be hospitalized. § 37-3-82(a).</p>	<p>The court may issue an order requiring the patient to comply with the new service plan or may order hospitalization. § 37-3-83(i); see also § 37-3-81(c), (d).</p>
Hawaii	<p>The family court shall designate the outpatient treatment psychiatrist who is to be responsible for the management and supervision of the subject's outpatient treatment, or shall designate an administrator of a community mental health center to designate such an outpatient treatment psychiatrist during the treatment period without court approval, and may designate either a publicly employed psychiatrist, or a private psychiatrist. § 334-127(c).</p>	<p>The outpatient treatment psychiatrist or psychiatrist's designee shall make all reasonable efforts to solicit the subject's compliance with the prescribed treatment authorized by the family court. If the subject fails or refuses to comply after the efforts to solicit compliance, the outpatient treatment psychiatrist shall so notify the court and may submit a petition for the involuntary hospitalization of the subject, provided that the refusal of treatment shall not constitute evidence towards any of the criteria for involuntary hospitalization. § 334-129(c).</p>		

(continued)

Table 4 (continued)

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
Illinois	The court shall have continuing authority to modify an order for alternative treatment if the patient fails to comply with the order or is otherwise found unsuitable for alternative treatment. § 3-812(b).		Prior to modifying its IOC order, the court shall receive a report from the facility director of the program specifying why the alternative treatment is unsuitable. The patient shall be notified and given an opportunity to respond when modification of the order for alternative treatment is considered. § 3-812(b).	If the court revokes an order for alternative treatment and orders a patient hospitalized, it may order a peace officer to take the patient into custody and transport him to the facility. § 3-812(c).
Iowa	If at any time the patient, without good cause fails or refuses to submit to treatment as ordered by the court, the medical director shall at once notify the court. § 229.15(2).	The commitment order shall provide that if the respondent fails or refuses to submit to treatment as directed by the court's order, the court may order that the respondent be taken into immediate custody. § 229.14(3).		Following a hearing, the court shall order the patient hospitalized, unless the court finds that the failure or refusal was with good cause and that the patient is willing to receive treatment as provided in the court's order, or in a revised order if the court sees fit to enter one. § 229.15(2).
Michigan	For any order of alternative treatment, or for the alternative treatment portion of an order of combined hospitalization and alternative treatment, the court order shall identify the agency or independent mental health practitioner who is directed to supervise the individual's alternative treatment program. § 330.1469(5). If the agency or practitioner believes that the individual is not complying with the court order or that the alternative treatment has not been sufficient to prevent harm or injuries which the individual may be inflicting upon himself or herself or upon others, the agency or practitioner shall notify the court immediately of this fact. § 330.1469(9)(a), (b).	If it comes to the attention of the court that the person is not complying with the order, or the alternative treatment program is not sufficient, the court, without a hearing and based upon the record and other available information, may (a) consider other alternatives to hospitalization and modify its original order, or (b) enter a new order directing that the person be hospitalized. § 330.1469(8)(a), (b).	No hearing required. § 330.1469(8). See "Revocation of IOC Status," this table, column 2.	The court may direct the individual to undergo another program of alternative treatment for the remainder of the 90-day period or may direct that the person be hospitalized for the remainder of the 90-day period or 60 days, or for the remainder of the 60-day hospitalization portion of the combined order, whichever is shorter. If the person refuses to comply, the court may direct a peace officer to take the person into protective custody and transport the person to a hospital. § 330.1469(8)(a), (b); see also § 330.1469(10).

(continued)

Table 4 (continued)

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
North Carolina	Any person who has knowledge that a respondent on outpatient commitment has become dangerous to self or others may initiate a new petition for inpatient commitment. § 122-58.10A(b)(5). The court shall indicate on the IOC order the person or mental health facility responsible for the management and supervision of the respondent's outpatient treatment. § 122-58.7A-1(h). See also § 122-58.8(a)(4).	If the respondent fails to comply, but does not clearly refuse to comply, with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance, the physician or his designee may request the court to order the respondent taken into custody for the purpose of examination. § 122-58.10A(b)(2); see also § 122-58.10A(b)(1). Inpatient commitment proceedings shall be initiated in cases when the respondent who refuses treatment poses immediate danger to himself or others. § 122-58.10A(b)(3).	Upon receipt of a request, a supplemental hearing for alleged noncompliance shall be held within 14 days. Procedures for supplemental hearing shall follow those governing the original proceedings. In all hearings for alleged noncompliance, the court must determine whether the respondent has failed to comply and, if so, the causes for noncompliance. § 122-58.10B(a).	If the court determines that the respondent has failed or refused to comply it may: (1) upon finding probable cause to believe that the respondent is mentally ill and dangerous to himself or others, order an examination order to determine the necessity for continued outpatient or inpatient commitment; (2) reissue or modify the outpatient commitment order; or (3) discharge the respondent from the order and dismiss the case. § 122-58.10B(a)(1)-(3).
North Dakota		If during the alternative treatment period, the court learns that the respondent is not complying with the IOC order, or that the alternative treatment has not been sufficient to prevent harm or injuries that the individual may be inflicting upon himself or others, the court may modify its original order or enter a new order. § 25-03.1-21.	The court may without a hearing and based upon the record and other available information consider and modify its original order. § 25-03.1-21.	The court may direct the individual to undergo another program of alternative treatment or enter a new order directing the individual to be hospitalized for the remainder of the 90-day period. § 25-03.1-21, 21.2.

(continued)

Table 4 (continued)

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
Oklahoma		If at any time during the 90-day period it comes to the attention of the court from a person competent to file a petition that the individual ordered to undergo a program of alternative treatment to hospitalization is not complying with the order or that the alternative treatment program has not been sufficient to prevent harm or injury which the individual may be inflicting upon himself or others, the court may consider other alternatives to hospitalization, modify or rescind the original order. § 54.9.B.	Immediately upon the issuance of an ex parte modification order, the court shall give notice to the person to appear within 5 regular court days, or as many other days as the court may grant, and show cause why said modification shall not be made. The notice shall contain the following: a statement of the facts upon which the alleged change of condition is based; notice of the types of modifications that the court can make pursuant to this hearing; names of witnesses who shall testify or offer evidence for the modification which are known to the court; that the individual has the right to an attorney; and that the individual has the right to cross-examine witnesses, and to call witnesses in such person's own defense. § 54.10.	The court may direct the individual to undergo another program of alternative treatment for the remainder of the 90-day period, or for a period not to exceed 12 months, if necessary and appropriate, based on written findings of the court; or enter an order of admission directing that the person be hospitalized. § 54.9 B.1, 2.
Oregon		The custody order may be revoked and the mentally ill person committed to the Division for the balance of the 180-day commitment period whenever, in the opinion of the court, it is in the best interest of the mentally ill person. § 426.130(2).		
South Carolina		If the respondent fails to adhere to the prescribed outpatient treatment program, on report of the failure by the treatment facility, the court upon notice to the respondent and his counsel may order a supplemental hearing. § 44-17-580(2).		Following the supplemental hearing, the court may order inpatient treatment in a designated or licensed facility. § 44-17-580(2).

(continued)

Table 4 (continued)

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
South Dakota		<p>If at any time it comes to the attention of the Board that treatment has not been successful or if an individual ordered to undergo a program of treatment does not comply with the order, the Board shall conduct a hearing and may modify its original order. §§ 27A-9-28, 29.</p>	<p>The Board shall conduct a hearing for the sole purpose of determining compliance or noncompliance. § 27A-9-28. At least 5 days notice of the hearing shall be given to the mentally ill person and he shall be represented by counsel. § 27A-9-29.</p>	<p>The Board may modify its original order and direct the individual to undergo an alternative program of treatment. §§ 27A-9-28, 29.</p>
Texas	<p>An order directing that a person participate in outpatient mental health services shall identify an individual to be responsible for those services. This individual shall be the head of a mental health facility or an individual involved in providing the services in which the patient is to participate under the order. If the person ordered to participate in outpatient mental health services fails to comply with the terms of the court's order, the individual responsible shall inform the court of such failure to comply. The individual responsible shall also inform the court of any substantial changes in the general program of treatment which may occur prior to the expiration of the order. § 5547-52(a), (c).</p>	<p>On its own motion or at the request of the individual responsible or any other interested individual, the court which entered an order directing the person to participate in outpatient mental health services may set a hearing to determine whether the order should be modified. If a hearing on modification is set, the court may order protective custody pending the hearing. § 5547-53(a), (b).</p>	<p>A hearing on a request for modification of an order for outpatient mental health services shall be before the court without a jury. The person shall be represented by an attorney and receive proper notice, and the hearing shall be held pursuant to the requirements of the initial hearing. § 5547-53(d). At the hearing, the court may modify the order if it determines either that the person has not complied with the court's order or that the person's condition has so deteriorated that outpatient mental health services are no longer appropriate. § 5547-53(e).</p>	<p>The court may decline to modify the order and direct that the person continue to participate in outpatient mental health services pursuant to the terms of the order, or if a revised general program of treatment has been submitted and accepted by the court, modify the order so as to incorporate that revised treatment program and to provide for continued outpatient mental health services pursuant to the modified order; or modify the order to provide for the commitment of the person to a facility for inpatient care. In no case may the modified order extend beyond the time period of the original order. § 5547-53(f), (g).</p>

(continued)

Table 4 (continued)

State	Monitoring and Compliance Review	Revocation of IOC Status	Revocation Proceeding	Disposition Following Revocation
Vermont	All court orders of hospitalization, non-hospitalization and continued treatment shall be directed to the commissioner and shall admit the patient to his care and custody for the period specified. § 7623.	If at any time during the specified period of non-hospitalization it comes to the attention of the court, either that the patient is not complying with the order or that the alternative treatment has not been adequate to meet the patient's treatment needs, the court may order a new hearing. § 7618(b); see also § 7621(c).		After proper hearing, the court may consider other alternatives, modify its original order and direct the patient to undergo another program of alternative treatment for the remainder of the 90-day period; or enter a new order directing that the patient be hospitalized for the remainder of the 90-day period. § 7618(b)(1), (2); see also § 7621(c)(1), (2).
Washington		An order for treatment less restrictive than involuntary detention may include conditions, and if such conditions are not adhered to, the designated mental health professional may order the person apprehended. § 71.05.320(1).		
Wisconsin		The court order may direct that, if the director or his or her designee determines that the individual has failed to take the medication as prescribed or has failed to report for evaluation as directed, the director or designee may request that the individual be taken into custody by a law enforcement agency and that medication, as prescribed by the physician, may be administered voluntarily or against the will of the individual. A court order under this paragraph is effective only as long as the commitment is in effect. § 51.20(13)(dm).		See "Revocation of IOC," this table, column 2.

